

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: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 9:13 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION 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 BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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	Timothy Moore	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	Timothy Moore		2
3	Signatory Title	VP-FINANCE, CAO		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	-191,710	-469,972	0	0	1.00
2.00 Subprovider - IPF	0	28,005	-76		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	-169,795	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		58,422		0	10.00
200.00 Total	0	-333,500	-411,626	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: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:13 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 640 WEST WASHINGTON			PO Box:				1.00		
2.00	City: PITTSFIELD			State: IL		Zip Code: 62363		County:		
		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		BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N
4.00	Subprovider - IPF		BCC DBA ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		BCC DBA ILLINI COMM HOSP RHC	143482	99914		07/03/2006	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020	09/30/2021		20.00
21.00	Type of Control (see instructions)						2			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.					0				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 9:13 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 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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	N	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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:13 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	66,578	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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)	Y	14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 9:13 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: BLESSING CORPORATE SERVICES		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00		
142.00	Street: BROADWAY AT 11TH STREET		PO Box:				142.00		
143.00	City: QUINCY		State: IL		Zip Code: 62301		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	
								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	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
								4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N		N		N	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	
				Name		County		State	
				0		1.00		2.00	
								3.00	
								4.00	
								FTE/Campus	
								5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	
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	
								Beginning	
								1.00	
								Ending	
								2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
								1.00	
								2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 9:13 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2021	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: 14-1315
Period: From 10/01/2020 To 09/30/2021
Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 9:13 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
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.	REIMBURSEMENT COORDINATOR		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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:13 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	24,816.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	24,816.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	24,816.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		35			0	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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:13 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)	673	13	1,034			1.00
2.00	HMO and other (see instructions)	137	77				2.00
3.00	HMO IPF Subprovider	163	245				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	456	0	456			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	100			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,129	13	1,590			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,129	13	1,590	0.00	150.37	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	727	48	1,546	0.00	18.37	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,465	0	9,942	0.00	18.44	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	187.18	27.00
28.00	Observation Bed Days		0	147			28.00
29.00	Ambulance Trips	0					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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 9:13 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	177	4	286	1.00
2.00 HMO and other (see instructions)			32	24		2.00
3.00 HMO IPF Subprovider				33		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	177	4	286	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	91	11	202	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2020 To 09/30/2021
			Worksheet S-8		Date/Time Prepared: 2/28/2022 9:13 am
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		640 WEST WASHINGTON		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		PITTSFIELD IL 62363		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
			1.00	2.00	3.00
			Tuesday		from
			5.00		
11.00	Facility hours of operations (1)				
	CLINIC		07:00	17:00	07:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			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)				
			County		4.00
2.00	City, State, ZIP Code, County		PIKE		2.00
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			9.00		10.00
11.00	Facility hours of operations (1)				
	CLINIC		17:00	07:00	17:00
			07:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/28/2022 9:13 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	07:00	17:00	08:00	11:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/28/2022 9:13 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)			0.388052 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,550,502		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	1,311,619		5.00
6.00	Medicaid charges	12,856,247		6.00
7.00	Medicaid cost (line 1 times line 6)	4,988,892		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,126,771		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,126,771		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)	360,305	739,911	1,100,216 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	139,817	739,911	879,728 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)	139,817	739,911	879,728 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)	1,470,133		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	390,907		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	601,395		27.01
28.00	Non-Medicare bad debt expense (see instructions)	868,738		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	547,604		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,427,332		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,554,103		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		766,485	766,485	51,487	817,972	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		424,922	424,922	3,213	428,135	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,451,108	4,451,108	0	4,451,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,072,311	3,424,505	5,496,816	63,868	5,560,684	5.00
6.00	00600	MAINTENANCE & REPAIRS	434,090	378,240	812,330	0	812,330	6.00
7.00	00700	OPERATION OF PLANT	0	601,893	601,893	44,839	646,732	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,246	47,246	0	47,246	8.00
9.00	00900	HOUSEKEEPING	341,348	184,713	526,061	0	526,061	9.00
10.00	01000	DIETARY	217,249	144,070	361,319	0	361,319	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	388,244	6,777	395,021	-78,794	316,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,652	40,061	72,713	0	72,713	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	186,243	186,243	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	247,609	247,609	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,003,150	165,976	1,169,126	-83,386	1,085,740	30.00
40.00	04000	SUBPROVIDER - IPF	981,799	48,572	1,030,371	-102,911	927,460	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	472,979	54,216	527,195	6,729	533,924	50.00
53.00	05300	ANESTHESIOLOGY	247,609	8,210	255,819	-255,819	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	857,927	270,459	1,128,386	0	1,128,386	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	92,597	26,750	119,347	-22,311	97,036	54.01
60.00	06000	LABORATORY	503,742	1,406,181	1,909,923	-46,644	1,863,279	60.00
65.00	06500	RESPIRATORY THERAPY	45,670	38,702	84,372	-11,818	72,554	65.00
65.01	03610	SLEEP LAB	0	31,599	31,599	0	31,599	65.01
66.00	06600	PHYSICAL THERAPY	0	48,477	48,477	0	48,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,524	6,752	69,276	0	69,276	67.00
68.00	06800	SPEECH PATHOLOGY	24,191	8,060	32,251	0	32,251	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,899	309,882	411,781	81,192	492,973	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451,758	2,689,139	3,140,897	-251	3,140,646	73.00
73.01	03480	ONCOLOGY	131,373	201,828	333,201	0	333,201	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,588,502	221,001	1,809,503	-103	1,809,400	88.00
91.00	09100	EMERGENCY	2,708,108	1,443,127	4,151,235	0	4,151,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		67,863	67,863	0	67,863	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,759,722	17,516,814	30,276,536	83,143	30,359,679	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	84,542	38,564	123,106	0	123,106	192.00
192.01	19201	XPRESS CARE	474,993	44,498	519,491	0	519,491	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	139,134	79,044	218,178	-83,143	135,035	193.04
193.05	19305	RETAIL PHARMACY	0	6,520	6,520	0	6,520	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	13,458,391	17,685,440	31,143,831	0	31,143,831	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
2/28/2022 9:13 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	136,162	954,134	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	122,284	550,419	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-873,376	3,577,732	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	506,404	6,067,088	5.00
6.00	00600	MAINTENANCE & REPAIRS	-14,981	797,349	6.00
7.00	00700	OPERATION OF PLANT	-30,289	616,443	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,326	44,920	8.00
9.00	00900	HOUSEKEEPING	0	526,061	9.00
10.00	01000	DIETARY	-74,351	286,968	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	316,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	253,618	326,331	16.00
17.00	01700	SOCIAL SERVICE	192,293	378,536	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	247,609	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,810	1,094,550	30.00
40.00	04000	SUBPROVIDER - IPF	-12,958	914,502	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,463	529,461	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-63,008	1,065,378	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	97,036	54.01
60.00	06000	LABORATORY	-325,353	1,537,926	60.00
65.00	06500	RESPIRATORY THERAPY	0	72,554	65.00
65.01	03610	SLEEP LAB	-5,103	26,496	65.01
66.00	06600	PHYSICAL THERAPY	0	48,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	69,276	67.00
68.00	06800	SPEECH PATHOLOGY	0	32,251	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,592	567,565	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,588	3,152,234	73.00
73.01	03480	ONCOLOGY	-247,341	85,860	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-73,405	1,735,995	88.00
91.00	09100	EMERGENCY	-1,353,538	2,797,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-67,863	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,842,604	28,517,075	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-132	122,974	192.00
192.01	19201	XPRESS CARE	0	519,491	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	RENAL	0	0	193.01
193.02	19302	LEASED SPACE	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	193.03
193.04	19304	WELLNESS	0	135,035	193.04
193.05	19305	RETAIL PHARMACY	0	6,520	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,842,736	29,301,095	200.00

RECLASSIFICATIONS

Provider CCN: 14-1315

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 9:13 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,000		1.00
	0		0	10,000		
	B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	44,839		1.00
2.00		0.00	0	0		2.00
	0		0	44,839		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	81,192		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	81,192		
	E - RECLASS INFECTION CONTROL SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	78,794	0		1.00
	0		78,794	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	8,210		1.00
	0		0	8,210		
	H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	247,609	0		1.00
	0		247,609	0		
	J - RECLASS SOCIAL WORKER SALARIES					
1.00	SOCIAL SERVICE	17.00	186,243	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		186,243	0		
	K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,700		1.00
	0		0	44,700		
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	24,515	13,928		1.00
	0		24,515	13,928		
500.00	Grand Total: Increases		537,161	202,869		500.00

RECLASSIFICATIONS

Provider CCN: 14-1315

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 9:13 am

	Decreases						27/03/2022 04:10 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	0		0	10,000			
	B - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,369	0		1.00
2.00	OPERATING ROOM	50.00	0	1,470	0		2.00
	0		0	44,839			
	C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	54	0		1.00
2.00	OPERATING ROOM	50.00	0	11	0		2.00
3.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	22,311	0		3.00
4.00	LABORATORY	60.00	0	46,644	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	11,818	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	251	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	103	0		7.00
	0		0	81,192			
	E - RECLASS INFECTION CONTROL SALARY						
1.00	NURSING ADMINISTRATION	13.00	78,794	0	0		1.00
	0		78,794	0			
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	8,210	0		1.00
	0		0	8,210			
	H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	247,609	0	0		1.00
	0		247,609	0			
	J - RECLASS SOCIAL WORKER SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	79,814	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	3,518	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	18,594	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	84,317	0	0		4.00
	0		186,243	0			
	K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.04	0	44,700	10		1.00
	0		0	44,700			
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.04	24,515	13,928	0		1.00
	0		24,515	13,928			
500.00	Grand Total: Decreases		537,161	202,869			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 9:13 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	279,691	17,875	0	17,875	0	1.00	
2.00	Land Improvements	533,487	0	0	0	0	2.00	
3.00	Buildings and Fixtures	12,754,290	35,843	0	35,843	15,398	3.00	
4.00	Building Improvements	5,251,159	212,309	0	212,309	24,240	4.00	
5.00	Fixed Equipment	73,264	0	0	0	0	5.00	
6.00	Movable Equipment	7,956,654	918,903	0	918,903	251,427	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	26,848,545	1,184,930	0	1,184,930	291,065	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	26,848,545	1,184,930	0	1,184,930	291,065	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	297,566	0					1.00
2.00	Land Improvements	533,487	0					
3.00	Buildings and Fixtures	12,774,735	0					
4.00	Building Improvements	5,439,228	0					4.00
5.00	Fixed Equipment	73,264	0					
6.00	Movable Equipment	8,624,130	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	27,742,410	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	27,742,410	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 9:13 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	766,485	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	424,922	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,191,407	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	766,485				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	424,922				2.00
3.00	Total (sum of lines 1-2)	0	1,191,407				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 9:13 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	18,213,963	0	18,213,963	0.678661	6,787	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,624,130	0	8,624,130	0.321339	3,213	2.00
3.00	Total (sum of lines 1-2)	26,838,093	0	26,838,093	1.000000	10,000	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	6,787	902,647	44,700	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,213	547,206	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,449,853	44,700	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	6,787	0	0	954,134	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,213	0	0	550,419	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	1,504,553	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 9:13 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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-67,863	INTEREST EXPENSE	113.00	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	-1,219,732			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	878,267			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-68,514	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-850	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-5	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-7,452	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 9:13 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #
			1.00	2.00	3.00	4.00
						5.00
33.01	UTILITY REBATES	B		-25,521	OPERATION OF PLANT	7.00
33.02	MISCELLANEOUS SUPPLIES REVENUE	B		-7,806	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
33.03	MISCELLANEOUS	B		-4,325	DIETARY	10.00
33.04	PHYSICIAN RECRUITMENT	A		-25,000	ADMINISTRATIVE & GENERAL	5.00
33.05	CABLE TELEVISION	A		-4,768	OPERATION OF PLANT	7.00
33.06	MISCELLANEOUS EXPENSE	A		-6,000	ADMINISTRATIVE & GENERAL	5.00
33.07	PUBLIC RELATIONS EXPENSES	A		-80,039	ADMINISTRATIVE & GENERAL	5.00
33.08	ASSET RELIFING	A		136,162	CAP REL COSTS-BLDG & FIXT	1.00
33.09	ASSET RELIFING	A		134,122	CAP REL COSTS-MVBLE EQUIP	2.00
33.10	LOBBYING EXPENSE	A		-11,971	ADMINISTRATIVE & GENERAL	5.00
33.11	MISCELLANEOUS	B		-505	ADMINISTRATIVE & GENERAL	5.00
33.12	MISCELLANEOUS	B		-420	RURAL HEALTH CLINIC	88.00
33.13	MISCELLANEOUS	B		-48,629	RADIOLOGY-DIAGNOSTIC	54.00
33.14	MISCELLANEOUS	B		-158	OPERATING ROOM	50.00
33.15	MISCELLANEOUS	B		-2,400	EMERGENCY	91.00
33.16	MISCELLANEOUS	B		-1,234	DIETARY	10.00
33.17	MISCELLANEOUS	B		-15,196	RURAL HEALTH CLINIC	88.00
33.18	ACCOUNTING FEES	B		-1,969	ADMINISTRATIVE & GENERAL	5.00
33.19	LABORATORY EXPENSE	A		-117,771	RURAL HEALTH CLINIC	88.00
33.20	CT SCANNER DEPRECIATION ADJUSTMENT	A		-3,318	CAP REL COSTS-MVBLE EQUIP	2.00
33.21	PHYSICIAN TAIL COVERAGE	A		-33	ADMINISTRATIVE & GENERAL	5.00
33.22	CONTRACT PHARMACY DISPENSING FEES	A		-25,740	DRUGS CHARGED TO PATIENTS	73.00
33.23	NURSE PRACTITIONER WAGES	A		-15,898	ADULTS & PEDIATRICS	30.00
33.24	NURSE PRACTITIONER WAGES	A		-49,341	ONCOLOGY	73.01
33.25	NURSE PRACTITIONER WAGES	A		-341,538	EMERGENCY	91.00
33.26	NURSE PRACTITIONER WAGES	A		-2,926	OPERATING ROOM	50.00
33.27	NURSE PRACTITIONER BENEFITS	A		-130,408	EMPLOYEE BENEFITS DEPARTMENT	4.00
33.28	PROVIDER TAX	A		-703,957	ADMINISTRATIVE & GENERAL	5.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-1,842,736		

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 9:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,970,126	1,594,544	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	254,468	0	2.00
3.00	17.00	SOCIAL SERVICE	CARE MANAGEMENT	192,293	0	3.00
4.00	10.00	DIETARY	DIETICIAN	3,831	4,104	4.00
4.01	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	121,390	123,716	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	742,968	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	0	13,757	4.03
4.04	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	102,962	65,551	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	0	6,642	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	0	11,853	4.06
4.07	60.00	LABORATORY	LABORATORY TESTS	156,775	539,449	4.07
4.08	65.01	SLEEP LAB	SLEEP STUDIES	26,496	31,599	4.08
4.09	30.00	ADULTS & PEDIATRICS	BIO-MED	815	1,938	4.09
4.10	40.00	SUBPROVIDER - IPF	BIO-MED	24	57	4.10
4.11	50.00	OPERATING ROOM	BIO-MED	288	684	4.11
4.12	91.00	EMERGENCY	BIO-MED	575	1,368	4.12
4.13	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	96	228	4.13
4.14	50.00	OPERATING ROOM	BIO-MED	714	1,697	4.14
4.15	60.00	LABORATORY	BIO-MED	360	855	4.15
4.16	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	10,433	24,812	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	BIO-MED	60	143	4.17
4.18	6.00	MAINTENANCE & REPAIRS	BIO-MED	10,869	25,850	4.18
4.19	30.00	ADULTS & PEDIATRICS	TELEMETRY	36,841	11,010	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	82,398	0	4.20
4.21	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	0	8,520	4.21
4.22	60.00	LABORATORY	RIVERCROSS LABORATORY TESTS	109,576	51,760	4.22
4.23	88.00	RURAL HEALTH CLINIC	RURAL HEALTH CLINIC MANAGER	59,982	0	4.23
4.27	0.00			0	0	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,141,372	3,263,105	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B		0.00	BLESS CORP SVCS	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

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

Provider CCN: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 9:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,375,582	0		1.00
2.00	254,468	0		2.00
3.00	192,293	0		3.00
4.00	-273	0		4.00
4.01	-2,326	0		4.01
4.02	-742,968	0		4.02
4.03	-13,757	0		4.03
4.04	37,411	0		4.04
4.05	-6,642	0		4.05
4.06	-11,853	0		4.06
4.07	-382,674	0		4.07
4.08	-5,103	0		4.08
4.09	-1,123	0		4.09
4.10	-33	0		4.10
4.11	-396	0		4.11
4.12	-793	0		4.12
4.13	-132	0		4.13
4.14	-983	0		4.14
4.15	-495	0		4.15
4.16	-14,379	0		4.16
4.17	-83	0		4.17
4.18	-14,981	0		4.18
4.19	25,831	0		4.19
4.20	82,398	0		4.20
4.21	-8,520	9		4.21
4.22	57,816	0		4.22
4.23	59,982	0		4.23
4.27	0	9		4.27
5.00	878,267			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE	6.00
7.00	HOSPITAL	7.00
8.00	LAUNDRY	8.00
9.00	BIO-MED	9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1315

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

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 9:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	29,948	0	29,948	0	0	1.00
2.00	73.01	ONCOLOGY	198,000	198,000	0	0	0	2.00
3.00	91.00	EMERGENCY	2,808,435	1,008,411	1,800,024	0	0	3.00
4.00	91.00	EMERGENCY	396	396	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	3,450	0	3,450	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	12,925	12,925	0	0	0	6.00
7.00	40.00	SUBPROVIDER - IPF	960	0	960	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,054,114	1,219,732	1,834,382		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	198,000		2.00
3.00	91.00	EMERGENCY	0	0	0	1,008,411		3.00
4.00	91.00	EMERGENCY	0	0	0	396		4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	12,925		6.00
7.00	40.00	SUBPROVIDER - IPF	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,219,732		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2022 9:13 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					225	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	510.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.73	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.87	43.87	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					44,764	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					44,764	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					44,764	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					87.73	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					68,429	22.00
23.00	Total salary equivalency (see instructions)					68,429	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,871	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,871	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					776	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,647	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,647	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2022 9:13 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.73	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						68,429	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						10,647	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						79,076	63.00
64.00	Total cost of outside supplier services (from your records)						48,477	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9,871	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						776	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						10,647	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						776	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						776	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2022 9:13 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					49	1.00
2.00	Line 1 multiplied by 15 hours per week					735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					49	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	58.55	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.57	41.57	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					4,868	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,868	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,868	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					83.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					61,108	22.00
23.00	Total salary equivalency (see instructions)					61,108	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,037	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,037	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					169	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,206	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,206	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

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				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.14	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					61,108	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					2,206	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					63,314	63.00
64.00	Total cost of outside supplier services (from your records)					5,559	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					2,037	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					169	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					2,206	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					169	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					169	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2022 9:13 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					74	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	124.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.89	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.95	39.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,906	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					9,906	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					9,906	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					79.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					62,314	22.00
23.00	Total salary equivalency (see instructions)					62,314	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,956	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,956	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					255	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,211	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,211	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2022 9:13 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.89	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						62,314	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,211	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						65,525	63.00
64.00	Total cost of outside supplier services (from your records)						8,060	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,956	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						255	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,211	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						255	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						255	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	954,134	954,134			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	550,419		550,419		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,577,732	0	0	3,577,732	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,067,088	249,497	153,251	656,686	5.00
6.00	00600	MAINTENANCE & REPAIRS	797,349	166,691	102,389	133,258	6.00
7.00	00700	OPERATION OF PLANT	616,443	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,920	7,352	4,516	0	8.00
9.00	00900	HOUSEKEEPING	526,061	15,809	9,711	104,787	9.00
10.00	01000	DIETARY	286,968	11,078	6,805	66,691	10.00
11.00	01100	CAFETERIA	0	4,270	2,623	0	11.00
13.00	01300	NURSING ADMINISTRATION	316,227	1,434	881	94,995	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	326,331	10,345	6,354	10,024	16.00
17.00	01700	SOCIAL SERVICE	378,536	1,030	633	57,173	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	247,609	0	0	76,011	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,094,550	57,558	35,355	277,486	30.00
40.00	04000	SUBPROVIDER - IPF	914,502	45,944	28,221	269,802	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	529,461	44,411	27,279	144,297	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,065,378	28,066	17,240	263,367	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	97,036	3,627	2,228	28,426	54.01
60.00	06000	LABORATORY	1,537,926	16,444	10,101	154,639	60.00
65.00	06500	RESPIRATORY THERAPY	72,554	9,570	5,878	14,020	65.00
65.01	03610	SLEEP LAB	26,496	824	506	0	65.01
66.00	06600	PHYSICAL THERAPY	48,477	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,276	0	0	19,194	67.00
68.00	06800	SPEECH PATHOLOGY	32,251	0	0	7,426	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,565	7,039	4,324	31,281	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,152,234	11,169	6,860	138,681	73.00
73.01	03480	ONCOLOGY	85,860	25,494	15,660	25,182	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,735,995	47,890	29,416	487,640	88.00
91.00	09100	EMERGENCY	2,797,697	41,543	25,518	309,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,517,075	807,085	495,749	3,370,779	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	122,974	25,635	15,746	25,953	192.00
192.01	19201	XPRESS CARE	519,491	0	9,807	145,814	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	14,235	0	0	193.01
193.02	19302	LEASED SPACE	0	55,712	0	0	193.02
193.03	19303	UNUSED SPACE	0	4,064	0	0	193.03
193.04	19304	WELLNESS	135,035	47,403	29,117	35,186	193.04
193.05	19305	RETAIL PHARMACY	6,520	0	0	0	193.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	29,301,095	954,134	550,419	3,577,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,126,522					5.00
6.00	00600	MAINTENANCE & REPAIRS	385,559	1,585,246				6.00
7.00	00700	OPERATION OF PLANT	198,114	0	814,557			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,251	21,197	11,133	107,369		8.00
9.00	00900	HOUSEKEEPING	210,946	45,579	23,938	0	936,831	9.00
10.00	01000	DIETARY	119,407	31,939	16,774	0	19,705	10.00
11.00	01100	CAFETERIA	2,215	12,310	6,465	0	7,595	11.00
13.00	01300	NURSING ADMINISTRATION	132,904	4,135	2,172	0	2,551	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,466	29,824	15,664	0	18,400	16.00
17.00	01700	SOCIAL SERVICE	140,564	2,970	1,560	0	1,833	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	104,006	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	470,810	165,945	87,153	54,438	102,381	30.00
40.00	04000	SUBPROVIDER - IPF	404,451	132,460	69,569	52,931	81,722	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	239,574	128,040	67,247	0	78,995	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,597	80,916	42,498	0	49,922	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	42,203	10,456	5,492	0	6,451	54.01
60.00	06000	LABORATORY	552,493	47,409	24,900	0	29,249	60.00
65.00	06500	RESPIRATORY THERAPY	32,788	27,590	14,490	0	17,022	65.00
65.01	03610	SLEEP LAB	8,943	2,376	1,248	0	1,466	65.01
66.00	06600	PHYSICAL THERAPY	15,580	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,433	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,752	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	196,111	20,294	10,659	0	12,521	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,063,427	32,200	16,912	0	19,866	73.00
73.01	03480	ONCOLOGY	48,913	73,502	38,604	0	45,348	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	739,483	138,069	72,514	0	85,182	88.00
91.00	09100	EMERGENCY	1,020,221	119,770	62,904	0	73,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,743,211	1,126,981	591,896	107,369	654,102	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	61,162	73,906	38,816	0	45,597	192.00
192.01	19201	XPRESS CARE	216,970	46,031	0	0	28,399	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	4,575	41,040	21,555	0	25,320	193.01
193.02	19302	LEASED SPACE	17,905	160,621	84,359	0	99,096	193.02
193.03	19303	UNUSED SPACE	1,306	0	6,153	0	0	193.03
193.04	19304	WELLNESS	79,298	136,667	71,778	0	84,317	193.04
193.05	19305	RETAIL PHARMACY	2,095	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,126,522	1,585,246	814,557	107,369	936,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	559,367					10.00
11.00	01100	CAFETERIA	0	35,478				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,384	556,683			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	146	0	530,554		16.00
17.00	01700	SOCIAL SERVICE	0	833	0	0	585,132	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,107	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	283,608	4,042	151,712	29,907	296,671	30.00
40.00	04000	SUBPROVIDER - IPF	275,759	3,930	98,227	30,164	288,461	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,102	56,720	29,304	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,551	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,837	20,886	162,744	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	414	0	5,173	0	54.01
60.00	06000	LABORATORY	0	2,253	0	89,584	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	204	0	3,060	0	65.00
65.01	03610	SLEEP LAB	0	0	0	2,193	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,696	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	280	0	2,507	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	108	0	739	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	456	1,677	19,595	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,020	0	68,767	0	73.00
73.01	03480	ONCOLOGY	0	367	8,994	2,210	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,105	59,757	21,779	0	88.00
91.00	09100	EMERGENCY	0	4,512	144,632	57,581	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	559,367	35,100	542,605	530,554	585,132	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	378	13,111	0	0	192.00
192.01	19201	XPRESS CARE	0	0	967	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
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)	559,367	35,478	556,683	530,554	585,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

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
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	428,733				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,111,616	0	3,111,616	30.00
40.00	04000	SUBPROVIDER - IPF	0	2,696,143	0	2,696,143	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,347,430	0	1,347,430	50.00
53.00	05300	ANESTHESIOLOGY	428,733	432,284	0	432,284	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,176,451	0	2,176,451	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	201,506	0	201,506	54.01
60.00	06000	LABORATORY	0	2,464,998	0	2,464,998	60.00
65.00	06500	RESPIRATORY THERAPY	0	197,176	0	197,176	65.00
65.01	03610	SLEEP LAB	0	44,052	0	44,052	65.01
66.00	06600	PHYSICAL THERAPY	0	65,753	0	65,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	119,690	0	119,690	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,276	0	53,276	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	871,522	0	871,522	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,512,136	0	4,512,136	73.00
73.01	03480	ONCOLOGY	0	370,134	0	370,134	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,424,830	0	3,424,830	88.00
91.00	09100	EMERGENCY	0	4,657,984	0	4,657,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	428,733	26,746,981	0	26,746,981	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	423,278	0	423,278	192.00
192.01	19201	XPRESS CARE	0	967,479	0	967,479	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	106,725	0	106,725	193.01
193.02	19302	LEASED SPACE	0	417,693	0	417,693	193.02
193.03	19303	UNUSED SPACE	0	11,523	0	11,523	193.03
193.04	19304	WELLNESS	0	618,801	0	618,801	193.04
193.05	19305	RETAIL PHARMACY	0	8,615	0	8,615	193.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	428,733	29,301,095	0	29,301,095	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,558	249,497	153,251	427,306	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	166,691	102,389	269,080	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,352	4,516	11,868	8.00
9.00	00900	HOUSEKEEPING	0	15,809	9,711	25,520	9.00
10.00	01000	DIETARY	0	11,078	6,805	17,883	10.00
11.00	01100	CAFETERIA	0	4,270	2,623	6,893	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,434	881	2,315	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,345	6,354	16,699	16.00
17.00	01700	SOCIAL SERVICE	0	1,030	633	1,663	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	57,558	35,355	92,913	30.00
40.00	04000	SUBPROVIDER - IPF	0	45,944	28,221	74,165	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	44,411	27,279	71,690	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,066	17,240	45,306	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,627	2,228	5,855	54.01
60.00	06000	LABORATORY	0	16,444	10,101	26,545	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,570	5,878	15,448	65.00
65.01	03610	SLEEP LAB	0	824	506	1,330	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,039	4,324	11,363	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,169	6,860	18,029	73.00
73.01	03480	ONCOLOGY	0	25,494	15,660	41,154	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	47,890	29,416	77,306	88.00
91.00	09100	EMERGENCY	0	41,543	25,518	67,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,558	807,085	495,749	1,327,392	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		25,635	15,746	41,381	192.00
192.01	19201	XPRESS CARE	22,980	0	9,807	32,787	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	14,235	0	14,235	193.01
193.02	19302	LEASED SPACE	0	55,712	0	55,712	193.02
193.03	19303	UNUSED SPACE	0	4,064	0	4,064	193.03
193.04	19304	WELLNESS	0	47,403	29,117	76,520	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	193.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	47,538	954,134	550,419	1,552,091	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	427,306					5.00
6.00	00600	MAINTENANCE & REPAIRS	23,118	292,198				6.00
7.00	00700	OPERATION OF PLANT	11,879	0	11,879			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,094	3,907	162	17,031		8.00
9.00	00900	HOUSEKEEPING	12,648	8,401	349	0	46,918	9.00
10.00	01000	DIETARY	7,160	5,887	245	0	987	10.00
11.00	01100	CAFETERIA	133	2,269	94	0	380	11.00
13.00	01300	NURSING ADMINISTRATION	7,969	762	32	0	128	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,803	5,497	228	0	922	16.00
17.00	01700	SOCIAL SERVICE	8,428	548	23	0	92	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,236	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,230	30,587	1,271	8,635	5,127	30.00
40.00	04000	SUBPROVIDER - IPF	24,251	24,416	1,015	8,396	4,093	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,365	23,601	981	0	3,956	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,478	14,915	620	0	2,500	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,530	1,927	80	0	323	54.01
60.00	06000	LABORATORY	33,127	8,739	363	0	1,465	60.00
65.00	06500	RESPIRATORY THERAPY	1,966	5,085	211	0	852	65.00
65.01	03610	SLEEP LAB	536	438	18	0	73	65.01
66.00	06600	PHYSICAL THERAPY	934	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,705	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	765	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,759	3,741	155	0	627	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,765	5,935	247	0	995	73.00
73.01	03480	ONCOLOGY	2,933	13,548	563	0	2,271	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	44,339	25,449	1,058	0	4,266	88.00
91.00	09100	EMERGENCY	61,172	22,076	917	0	3,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	404,323	207,728	8,632	17,031	32,758	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	3,667	13,623	566	0	2,284	192.00
192.01	19201	XPRESS CARE	13,009	8,485	0	0	1,422	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	274	7,565	314	0	1,268	193.01
193.02	19302	LEASED SPACE	1,074	29,606	1,230	0	4,963	193.02
193.03	19303	UNUSED SPACE	78	0	90	0	0	193.03
193.04	19304	WELLNESS	4,755	25,191	1,047	0	4,223	193.04
193.05	19305	RETAIL PHARMACY	126	0	0	0	0	193.05
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)	427,306	292,198	11,879	17,031	46,918	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	32,162					10.00
11.00	01100	CAFETERIA	0	9,769				11.00
13.00	01300	NURSING ADMINISTRATION	0	381	11,587			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40	0	30,189		16.00
17.00	01700	SOCIAL SERVICE	0	229	0	0	10,983	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	305	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,307	1,113	3,159	1,702	5,569	30.00
40.00	04000	SUBPROVIDER - IPF	15,855	1,082	2,044	1,716	5,414	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	579	1,180	1,668	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	202	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,056	435	9,259	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	114	0	294	0	54.01
60.00	06000	LABORATORY	0	620	0	5,098	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	56	0	174	0	65.00
65.01	03610	SLEEP LAB	0	0	0	125	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	96	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77	0	143	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	30	0	42	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125	35	1,115	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	556	0	3,913	0	73.00
73.01	03480	ONCOLOGY	0	101	187	126	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,959	1,244	1,239	0	88.00
91.00	09100	EMERGENCY	0	1,242	3,010	3,277	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,162	9,665	11,294	30,189	10,983	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	104	273	0	0	192.00
192.01	19201	XPRESS CARE	0	0	20	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
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)	32,162	9,769	11,587	30,189	10,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
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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
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,541				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		194,613	0	194,613	30.00
40.00	04000	SUBPROVIDER - IPF		162,447	0	162,447	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		118,020	0	118,020	50.00
53.00	05300	ANESTHESIOLOGY		202	0	202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		100,569	0	100,569	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		11,123	0	11,123	54.01
60.00	06000	LABORATORY		75,957	0	75,957	60.00
65.00	06500	RESPIRATORY THERAPY		23,792	0	23,792	65.00
65.01	03610	SLEEP LAB		2,520	0	2,520	65.01
66.00	06600	PHYSICAL THERAPY		1,030	0	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,925	0	1,925	67.00
68.00	06800	SPEECH PATHOLOGY		837	0	837	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		28,920	0	28,920	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		93,440	0	93,440	73.00
73.01	03480	ONCOLOGY		60,883	0	60,883	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		156,860	0	156,860	88.00
91.00	09100	EMERGENCY		162,456	0	162,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,195,594	0	1,195,594	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		61,898	0	61,898	192.00
192.01	19201	XPRESS CARE		55,723	0	55,723	192.01
193.00	19300	NONPAID WORKERS		0	0	0	193.00
193.01	19301	RENAL		23,656	0	23,656	193.01
193.02	19302	LEASED SPACE		92,585	0	92,585	193.02
193.03	19303	UNUSED SPACE		4,232	0	4,232	193.03
193.04	19304	WELLNESS		111,736	0	111,736	193.04
193.05	19305	RETAIL PHARMACY		126	0	126	193.05
200.00		Cross Foot Adjustments	6,541	6,541	0	6,541	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,541	1,552,091	0	1,552,091	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,756					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		108,714				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,654,590			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,269	30,269	2,139,190	-7,126,522	22,174,573	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	434,091	0	1,199,687	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	616,443	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	56,788	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	341,348	0	656,368	9.00
10.00	01000	DIETARY	1,344	1,344	217,249	0	371,542	10.00
11.00	01100	CAFETERIA	518	518	0	0	6,893	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	309,450	0	413,537	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	32,652	0	353,054	16.00
17.00	01700	SOCIAL SERVICE	125	125	186,243	0	437,372	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	247,609	0	323,620	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	903,920	0	1,464,949	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	878,888	0	1,258,469	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,388	5,388	470,053	0	745,448	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	857,927	0	1,374,051	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	92,597	0	131,317	54.01
60.00	06000	LABORATORY	1,995	1,995	503,742	0	1,719,110	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	45,670	0	102,022	65.00
65.01	03610	SLEEP LAB	100	100	0	0	27,826	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	48,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	62,524	0	88,470	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	24,191	0	39,677	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	101,899	0	610,209	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	451,758	0	3,308,944	73.00
73.01	03480	ONCOLOGY	3,093	3,093	82,032	0	152,196	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	1,588,502	0	2,300,941	88.00
91.00	09100	EMERGENCY	5,040	5,040	1,008,901	0	3,174,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,916	97,916	10,980,436	-7,126,522	20,981,881	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	3,110	3,110	84,542	0	190,308	192.00
192.01	19201	XPRESS CARE	0	1,937	474,993	0	675,112	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	0	0	0	14,235	193.01
193.02	19302	LEASED SPACE	6,759	0	0	0	55,712	193.02
193.03	19303	UNUSED SPACE	493	0	0	0	4,064	193.03
193.04	19304	WELLNESS	5,751	5,751	114,619	0	246,741	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	6,520	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	954,134	550,419	3,577,732		7,126,522	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.242631	5.063000	0.306981		0.321383	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		427,306	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019270	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: 14-1315

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	66,708				6.00
7.00	00700	OPERATION OF PLANT	0	65,264			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	3,136		8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	63,898	9.00
10.00	01000	DIETARY	1,344	1,344	0	1,344	3,136
11.00	01100	CAFETERIA	518	518	0	518	0
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0
17.00	01700	SOCIAL SERVICE	125	125	0	125	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,590	6,983	1,590
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,546	5,574	1,546
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,388	5,388	0	5,388	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	0	440	0
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	0	1,161	0
65.01	03610	SLEEP LAB	100	100	0	100	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	0	1,355	0
73.01	03480	ONCOLOGY	3,093	3,093	0	3,093	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,424	47,424	3,136	44,614	3,136
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	0	3,110	0
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	RENAL	1,727	1,727	0	1,727	0
193.02	19302	LEASED SPACE	6,759	6,759	0	6,759	0
193.03	19303	UNUSED SPACE	0	493	0	0	0
193.04	19304	WELLNESS	5,751	5,751	0	5,751	0
193.05	19305	RETAIL PHARMACY	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,585,246	814,557	107,369	936,831	559,367
203.00		Unit cost multiplier (Wkst. B, Part I)	23.763956	12.480954	34.237564	14.661351	178.369579
204.00		Cost to be allocated (per Wkst. B, Part II)	292,198	11,879	17,031	46,918	32,162
205.00		Unit cost multiplier (Wkst. B, Part II)	4.380254	0.182015	5.430804	0.734264	10.255740
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,933,100					11.00
13.00	01300	NURSING ADMINISTRATION	309,450	2,722,271				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,652	0	68,930,716			16.00
17.00	01700	SOCIAL SERVICE	186,243	0	0	3,136		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	247,609	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	903,920	741,896	3,885,543	1,590	0	30.00
40.00	04000	SUBPROVIDER - IPF	878,888	480,346	3,918,914	1,546	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	470,053	277,371	3,807,203	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	461,408	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	857,927	102,136	21,144,468	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	92,597	0	672,067	0	0	54.01
60.00	06000	LABORATORY	503,742	0	11,638,828	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	45,670	0	397,584	0	0	65.00
65.01	03610	SLEEP LAB	0	0	284,963	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	220,317	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,524	0	325,675	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,191	0	95,977	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,899	8,199	2,545,784	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451,758	0	8,934,255	0	0	73.00
73.01	03480	ONCOLOGY	82,032	43,984	287,165	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,588,502	292,220	2,829,543	0	0	88.00
91.00	09100	EMERGENCY	1,008,901	707,273	7,481,022	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,848,558	2,653,425	68,930,716	3,136	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	84,542	64,117	0	0	0	192.00
192.01	19201	XPRESS CARE	0	4,729	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	35,478	556,683	530,554	585,132	428,733	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004472	0.204492	0.007697	186.585459	4,287.330000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,769	11,587	30,189	10,983	6,541	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001231	0.004256	0.000438	3.502232	65.410000	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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:13 am

			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,111,616		3,111,616	0	3,111,616	30.00	
40.00	04000	SUBPROVIDER - IPF	2,696,143		2,696,143	0	2,696,143	40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,347,430		1,347,430	0	1,347,430	50.00	
53.00	05300	ANESTHESIOLOGY	432,284		432,284	0	432,284	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,176,451		2,176,451	0	2,176,451	54.00	
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	201,506		201,506	0	201,506	54.01	
60.00	06000	LABORATORY	2,464,998		2,464,998	0	2,464,998	60.00	
65.00	06500	RESPIRATORY THERAPY	197,176	0	197,176	0	197,176	65.00	
65.01	03610	SLEEP LAB	44,052	0	44,052	0	44,052	65.01	
66.00	06600	PHYSICAL THERAPY	65,753	0	65,753	0	65,753	66.00	
67.00	06700	OCCUPATIONAL THERAPY	119,690	0	119,690	0	119,690	67.00	
68.00	06800	SPEECH PATHOLOGY	53,276	0	53,276	0	53,276	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	871,522		871,522	0	871,522	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,512,136		4,512,136	0	4,512,136	73.00	
73.01	03480	ONCOLOGY	370,134		370,134	0	370,134	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,424,830		3,424,830	0	3,424,830	88.00	
91.00	09100	EMERGENCY	4,657,984		4,657,984	0	4,657,984	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	277,884		277,884		277,884	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	27,024,865	0	27,024,865	0	27,024,865	200.00	
201.00		Less Observation Beds	277,884		277,884		277,884	201.00	
202.00		Total (see instructions)	26,746,981	0	26,746,981	0	26,746,981	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:13 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,313,684		3,313,684			30.00
40.00	04000	SUBPROVIDER - IPF	3,918,914		3,918,914			40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,589	3,771,614	3,807,203	0.353916	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	461,408	461,408	0.936880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	935,787	20,208,681	21,144,468	0.102932	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	17,602	649,993	667,595	0.301839	0.000000	54.01
60.00	06000	LABORATORY	1,923,338	9,715,490	11,638,828	0.211791	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	327,664	69,920	397,584	0.495935	0.000000	65.00
65.01	03610	SLEEP LAB	0	284,963	284,963	0.154588	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	213,439	6,878	220,317	0.298447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	312,780	12,895	325,675	0.367514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,173	67,804	95,977	0.555091	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	305,968	2,239,816	2,545,784	0.342339	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,237	7,284,018	8,934,255	0.505038	0.000000	73.00
73.01	03480	ONCOLOGY	0	287,165	287,165	1.288924	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,829,543	2,829,543			88.00
91.00	09100	EMERGENCY	18,850	7,462,172	7,481,022	0.622640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	571,859	571,859	0.485931	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,002,025	55,924,219	68,926,244			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,002,025	55,924,219	68,926,244			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.353916			50.00
53.00	05300	ANESTHESIOLOGY	0.936880			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102932			54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.301839			54.01
60.00	06000	LABORATORY	0.211791			60.00
65.00	06500	RESPIRATORY THERAPY	0.495935			65.00
65.01	03610	SLEEP LAB	0.154588			65.01
66.00	06600	PHYSICAL THERAPY	0.298447			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.367514			67.00
68.00	06800	SPEECH PATHOLOGY	0.555091			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.505038			73.00
73.01	03480	ONCOLOGY	1.288924			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.622640			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485931			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	118,020	3,807,203	0.030999	27,375	849
53.00	05300	ANESTHESIOLOGY	202	461,408	0.000438	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,569	21,144,468	0.004756	528,460	2,513
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	11,123	667,595	0.016661	8,801	147
60.00	06000	LABORATORY	75,957	11,638,828	0.006526	784,154	5,117
65.00	06500	RESPIRATORY THERAPY	23,792	397,584	0.059841	156,863	9,387
65.01	03610	SLEEP LAB	2,520	284,963	0.008843	0	0
66.00	06600	PHYSICAL THERAPY	1,030	220,317	0.004675	33,400	156
67.00	06700	OCCUPATIONAL THERAPY	1,925	325,675	0.005911	56,597	335
68.00	06800	SPEECH PATHOLOGY	837	95,977	0.008721	11,349	99
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,920	2,545,784	0.011360	166,443	1,891
73.00	07300	DRUGS CHARGED TO PATIENTS	93,440	8,934,255	0.010459	602,607	6,303
73.01	03480	ONCOLOGY	60,883	287,165	0.212014	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	156,860	2,829,543	0.055437	0	0
91.00	09100	EMERGENCY	162,456	7,481,022	0.021716	1,566	34
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	17,380	571,859	0.030392	0	0
200.00		Total (lines 50 through 199)	855,914	61,693,646		2,377,615	26,831

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 9:13 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
53.00	05300	ANESTHESIOLOGY	428,733	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
65.01	03610	SLEEP LAB	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	03480	ONCOLOGY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
200.00		Total (lines 50 through 199)	428,733	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 9:13 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	3,807,203	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	428,733	0	461,408	0.929184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,144,468	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	667,595	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	11,638,828	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	397,584	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	284,963	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	220,317	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,675	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	95,977	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,545,784	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,934,255	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	287,165	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,829,543	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	7,481,022	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	571,859	0.000000	92.00
200.00		Total (lines 50 through 199)	0	428,733	0	61,693,646		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	27,375	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	528,460	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	8,801	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	784,154	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	156,863	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	33,400	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	56,597	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,349	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	166,443	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	602,607	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	1,566	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,377,615	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 9:13 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	0.353916	0	1,392,058	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.936880	0	111,633	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102932	0	7,975,280	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.301839	0	305,602	0	0	54.01
60.00	06000	LABORATORY	0.211791	0	3,623,678	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.495935	0	27,446	0	0	65.00
65.01	03610	SLEEP LAB	0.154588	0	115,814	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.298447	0	3,102	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.367514	0	5,168	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.555091	0	23,886	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339	0	622,559	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.505038	0	3,185,708	6,242	0	73.00
73.01	03480	ONCOLOGY	1.288924	0	139,064	0	0	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.622640	0	2,114,221	13,076	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485931	0	419,669	0	0	92.00
200.00		Subtotal (see instructions)		0	20,064,888	19,318	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	20,064,888	19,318	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 9:13 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	492,672	0		50.00
53.00	05300	ANESTHESIOLOGY	104,587	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,912	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	92,243	0		54.01
60.00	06000	LABORATORY	767,462	0		60.00
65.00	06500	RESPIRATORY THERAPY	13,611	0		65.00
65.01	03610	SLEEP LAB	17,903	0		65.01
66.00	06600	PHYSICAL THERAPY	926	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,899	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,259	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,126	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,608,904	3,152		73.00
73.01	03480	ONCOLOGY	179,243	0		73.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,316,399	8,142		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,930	0		92.00
200.00		Subtotal (see instructions)	5,847,076	11,294		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,847,076	11,294		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part II Date/Time Prepared: 2/28/2022 9:13 am	
				Title XVIII		Subprovider - IPF		PPS	
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		118,020	3,807,203	0.030999	0	0	50.00
53.00	05300	ANESTHESIOLOGY		202	461,408	0.000438	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		100,569	21,144,468	0.004756	54,451	259	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		11,123	667,595	0.016661	0	0	54.01
60.00	06000	LABORATORY		75,957	11,638,828	0.006526	230,009	1,501	60.00
65.00	06500	RESPIRATORY THERAPY		23,792	397,584	0.059841	14,267	854	65.00
65.01	03610	SLEEP LAB		2,520	284,963	0.008843	0	0	65.01
66.00	06600	PHYSICAL THERAPY		1,030	220,317	0.004675	8,867	41	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,925	325,675	0.005911	13,606	80	67.00
68.00	06800	SPEECH PATHOLOGY		837	95,977	0.008721	2,973	26	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		28,920	2,545,784	0.011360	15,204	173	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		93,440	8,934,255	0.010459	169,669	1,775	73.00
73.01	03480	ONCOLOGY		60,883	287,165	0.212014	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		156,860	2,829,543	0.055437	0	0	88.00
91.00	09100	EMERGENCY		162,456	7,481,022	0.021716	13,092	284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	571,859	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		838,534	61,693,646		522,138	4,993	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 9:13 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	428,733	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0	0	0	0	0	54.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
65.01	03610	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	03480	ONCOLOGY		0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	428,733	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315
Component CCN: 14-M315

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

Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 9:13 am

			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,807,203	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	428,733	0	461,408	0.929184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,144,468	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	667,595	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	11,638,828	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	397,584	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	284,963	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	220,317	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	325,675	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	95,977	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,545,784	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,934,255	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	287,165	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,829,543	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	7,481,022	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	571,859	0.000000	92.00
200.00		Total (lines 50 through 199)	0	428,733	0	61,693,646		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 9:13 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	54,451	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY		0.000000	230,009	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	14,267	0	0	0	65.00
65.01	03610	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	8,867	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	13,606	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	2,973	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	15,204	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	169,669	0	0	0	73.00
73.01	03480	ONCOLOGY		0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY		0.000000	13,092	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			522,138	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-M315

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 9:13 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Charges			Costs	
			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.353916	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.936880	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102932	0	0	0	0 54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.301839	0	0	0	0 54.01
60.00	06000	LABORATORY	0.211791	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.495935	0	0	0	0 65.00
65.01	03610	SLEEP LAB	0.154588	0	0	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.298447	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.367514	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.555091	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.505038	0	428	0	0 73.00
73.01	03480	ONCOLOGY	1.288924	0	0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	0.622640	0	84	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485931	0	0	0	0 92.00
200.00		Subtotal (see instructions)		0	512	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	512	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-M315

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 9:13 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	52	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	268	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	268	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 9:13 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)		1,737	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,181	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,034	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		114	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)		342	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		25	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)		75	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		673	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)		114	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)		342	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		168.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		171.55	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,111,616	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		4,205	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		12,866	25.00
26.00	Total swing-bed cost (see instructions)		879,084	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,232,532	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,232,532	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)		1,890.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,272,226	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,272,226	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 9:13 am

			Title XVIII		Hospital	Cost	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					709,972	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,982,198	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)					215,503	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					646,510	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					862,013	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)					147	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,890.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					277,884	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 9:13 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	194,613	3,111,616	0.062544	277,884	17,380
91.00	Nursing Program cost	0	3,111,616	0.000000	277,884	0
92.00	Allied health cost	0	3,111,616	0.000000	277,884	0
93.00	All other Medical Education	0	3,111,616	0.000000	277,884	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 9:13 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,546	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,546	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,546	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		727	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,696,143	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,696,143	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,696,143	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)		1,743.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,267,852	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,267,852	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 9:13 am	
				Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					169,737	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,437,589	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)					4,993	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,993	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,432,596	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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

Period:

Worksheet D-1

Component CCN: 14-M315

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:13 am

Title XVIII

Subprovider -
IPF

PPS

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	0	2,696,143	0.000000	0	0	90.00
91.00	Nursing Program cost	0	2,696,143	0.000000	0	0	91.00
92.00	Allied health cost	0	2,696,143	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,696,143	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 9:13 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		1,796,606		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.353916	27,375	9,688	50.00
53.00	05300	ANESTHESIOLOGY	0.936880	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102932	528,460	54,395	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.301839	8,801	2,656	54.01
60.00	06000	LABORATORY	0.211791	784,154	166,077	60.00
65.00	06500	RESPIRATORY THERAPY	0.495935	156,863	77,794	65.00
65.01	03610	SLEEP LAB	0.154588	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.298447	33,400	9,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.367514	56,597	20,800	67.00
68.00	06800	SPEECH PATHOLOGY	0.555091	11,349	6,300	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339	166,443	56,980	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.505038	602,607	304,339	73.00
73.01	03480	ONCOLOGY	1.288924	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.622640	1,566	975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485931	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,377,615	709,972	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,377,615		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 9:13 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
40.00	04000 SUBPROVIDER - IPF		1,835,603		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.353916	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.936880	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102932	54,451	5,605	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.301839	0	0	54.01
60.00	06000 LABORATORY	0.211791	230,009	48,714	60.00
65.00	06500 RESPIRATORY THERAPY	0.495935	14,267	7,076	65.00
65.01	03610 SLEEP LAB	0.154588	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.298447	8,867	2,646	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.367514	13,606	5,000	67.00
68.00	06800 SPEECH PATHOLOGY	0.555091	2,973	1,650	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339	15,204	5,205	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.505038	169,669	85,689	73.00
73.01	03480 ONCOLOGY	1.288924	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.622640	13,092	8,152	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.485931	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		522,138	169,737	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)		522,138		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 9:13 am	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.353916	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.936880	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102932	41,216	4,242	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.301839	0	0	54.01
60.00	06000	LABORATORY	0.211791	153,112	32,428	60.00
65.00	06500	RESPIRATORY THERAPY	0.495935	52,637	26,105	65.00
65.01	03610	SLEEP LAB	0.154588	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.298447	116,825	34,866	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.367514	161,332	59,292	67.00
68.00	06800	SPEECH PATHOLOGY	0.555091	4,755	2,639	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342339	37,239	12,748	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.505038	227,352	114,821	73.00
73.01	03480	ONCOLOGY	1.288924	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.622640	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485931	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		794,468	287,141	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)		794,468		202.00

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 9:13 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			5,858,370	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)			5,858,370	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			5,916,954	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)			34,560	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,234,905	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,647,489	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2,647,489	30.00
31.00	Primary payer payments			36	31.00
32.00	Subtotal (line 30 minus line 31)			2,647,453	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)			518,288	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			336,887	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			518,288	36.00
37.00	Subtotal (see instructions)			2,984,340	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2,984,340	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			3,454,312	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)			-469,972	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 9:13 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		268	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)		268	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		512	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)		512	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		512	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		244	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)		268	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)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		268	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)		268	30.00
31.00	Primary payer payments		36	31.00
32.00	Subtotal (line 30 minus line 31)		232	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		232	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)		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)		232	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		308	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)		-76	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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 9:13 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,213,231		3,602,585	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	05/26/2021	165,566	05/26/2021	148,273	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)		-165,566		-148,273	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,047,665		3,454,312	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		191,710		469,972	6.02
7.00	Total Medicare program liability (see instructions)		1,855,955		2,984,340	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: 14-1315
 Component CCN: 14-M315

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2022 9:13 am

		Title XVIII		Subprovider - IPF		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		701,520		308	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)		701,520		308	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		28,005		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		76	6.02	
7.00	Total Medicare program liability (see instructions)		729,525		232	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1315

Period:

Worksheet E-1

Component CCN: 14-Z315

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 9:13 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		1,496,689		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	05/26/2021	74,640		0	3.50
3.51		09/09/2021	99,196		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)		-173,836		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)		1,322,853		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		169,795		0	6.02
7.00	Total Medicare program liability (see instructions)		1,153,058		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/28/2022 9:13 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2 Date/Time Prepared: 2/28/2022 9:13 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)		870,633	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)		290,012	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		456	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)		1,160,645	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,160,645	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)		1,160,645	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		7,587	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,153,058	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)		1,153,058	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		1,322,853	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)		-169,795	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: 14-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/28/2022 9:13 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			1,982,198	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)			1,982,198	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,002,020	6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,002,020	19.00
20.00	Deductibles (exclude professional component)			168,000	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,834,020	22.00
23.00	Coinsurance			4,081	23.00
24.00	Subtotal (line 22 minus line 23)			1,829,939	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			40,024	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			26,016	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			40,024	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,855,955	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)			1,855,955	30.00
30.01	Sequestration adjustment (see instructions)			0	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			2,047,665	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)			-191,710	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part II Date/Time Prepared: 2/28/2022 9:13 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	735,920		
2.00	Net IPF PPS Outlier Payments	72,185		
3.00	Net IPF PPS ECT Payments	0		
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00		
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		
5.00	New Teaching program adjustment. (see instructions)	0.00		
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00		
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00		
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00		
9.00	Average Daily Census (see instructions)	4.235616		
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000		
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0		
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	808,105		
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0		
14.00	Organ acquisition (DO NOT USE THIS LINE)	0		
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0		
16.00	Subtotal (see instructions)	808,105		
17.00	Primary payer payments	0		
18.00	Subtotal (line 16 less line 17).	808,105		
19.00	Deductibles	94,712		
20.00	Subtotal (line 18 minus line 19)	713,393		
21.00	Coinsurance	11,872		
22.00	Subtotal (line 20 minus line 21)	701,521		
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	43,083		
24.00	Adjusted reimbursable bad debts (see instructions)	28,004		
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,083		
26.00	Subtotal (sum of lines 22 and 24)	729,525		
27.00	Direct graduate medical education payments (see instructions)	0		
28.00	Other pass through costs (see instructions)	0		
29.00	Outlier payments reconciliation	0		
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		
30.98	Recovery of accelerated depreciation.	0		
30.99	Demonstration payment adjustment amount before sequestration	0		
31.00	Total amount payable to the provider (see instructions)	729,525		
31.01	Sequestration adjustment (see instructions)	0		
31.02	Demonstration payment adjustment amount after sequestration	0		
32.00	Interim payments	701,520		
33.00	Tentative settlement (for contractor use only)	0		
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	28,005		
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	72,185		
51.00	Outlier reconciliation adjustment amount (see instructions)	0		
52.00	The rate used to calculate the Time Value of Money	0.00		
53.00	Time Value of Money (see instructions)	0		

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

Provider CCN: 14-1315

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

Worksheet G

Date/Time Prepared:
2/28/2022 9:13 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	15,428,698	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	11,610,609	0	0	0	4.00
5.00 Other receivable	269,313	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-7,631,000	0	0	0	6.00
7.00 Inventory	1,263,688	0	0	0	7.00
8.00 Prepaid expenses	217,930	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)	21,159,238	0	0	0	11.00
FIXED ASSETS					
12.00 Land	297,566	0	0	0	12.00
13.00 Land improvements	533,487	0	0	0	13.00
14.00 Accumulated depreciation	-462,470	0	0	0	14.00
15.00 Buildings	19,061,280	0	0	0	15.00
16.00 Accumulated depreciation	-8,219,676	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	8,546,710	0	0	0	23.00
24.00 Accumulated depreciation	-5,752,434	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)	14,004,463	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	6,805,461	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	118,607	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	6,924,068	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	42,087,769	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,197,590	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,380,801	0	0	0	38.00
39.00 Payroll taxes payable	46,894	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	263,488	0	0	0	43.00
44.00 Other current liabilities	5,752,641	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	9,641,414	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	1,474,373	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	717,832	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	2,192,205	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	11,833,619	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	30,254,150	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)	30,254,150	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	42,087,769	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1315

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

Worksheet G-1

Date/Time Prepared:
2/28/2022 9:13 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		24,280,420		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,973,730				2.00
3.00	Total (sum of line 1 and line 2)		30,254,150		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)		30,254,150		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)		30,254,150		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: 14-1315

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 9:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,748,068		2,748,068	1.00
2.00	SUBPROVIDER - IPF	3,986,428		3,986,428	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	466,288		466,288	5.00
6.00	Swing bed - NF	113,703		113,703	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)	7,314,487		7,314,487	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,314,487		7,314,487	17.00
18.00	Ancillary services	5,498,373	56,925,919	62,424,292	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,829,543	2,829,543	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICE	0	407,863	407,863	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,812,860	60,163,325	72,976,185	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,143,831		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,143,831		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1315

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

Worksheet G-3

Date/Time Prepared:
2/28/2022 9:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,976,185	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,510,502	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,465,683	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,143,831	4.00
5.00	Net income from service to patients (line 3 minus line 4)	321,852	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	7,655	6.00
7.00	Income from investments	1,157,278	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	72,839	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	116,453	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,628,875	24.00
24.50	COVID-19 PHE Funding	2,668,778	24.50
25.00	Total other income (sum of lines 6-24)	5,651,878	25.00
26.00	Total (line 5 plus line 25)	5,973,730	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)	5,973,730	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315

Period:

Worksheet M-1

Component CCN: 14-3482

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:13 am

		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	530,500	0	530,500	0	530,500	1.00
2.00 Physician Assistant	0	0	0	0	0	2.00
3.00 Nurse Practitioner	401,981	0	401,981	0	401,981	3.00
4.00 Visiting Nurse	0	0	0	0	0	4.00
5.00 Other Nurse	0	0	0	0	0	5.00
6.00 Clinical Psychologist	0	0	0	0	0	6.00
7.00 Clinical Social Worker	0	0	0	0	0	7.00
8.00 Laboratory Technician	0	0	0	0	0	8.00
9.00 Other Facility Health Care Staff Costs	270,579	0	270,579	0	270,579	9.00
10.00 Subtotal (sum of lines 1 through 9)	1,203,060	0	1,203,060	0	1,203,060	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	106,494	106,494	0	106,494	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	106,494	106,494	0	106,494	14.00
15.00 Medical Supplies	0	103	103	-103	0	15.00
16.00 Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00 Professional Liability Insurance	0	0	0	0	0	18.00
19.00 Other Health Care Costs	0	59,384	59,384	0	59,384	19.00
20.00 Allowable GME Costs	0	0	0	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	59,487	59,487	-103	59,384	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,203,060	165,981	1,369,041	-103	1,368,938	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	44,954	7,601	52,555	0	52,555	25.01
25.02 Chronic Care Management	75,770	14,423	90,193	0	90,193	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)	120,724	22,024	142,748	0	142,748	28.00
FACILITY OVERHEAD						
29.00 Facility Costs	0	736	736	0	736	29.00
30.00 Administrative Costs	264,718	32,260	296,978	0	296,978	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	264,718	32,996	297,714	0	297,714	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	1,588,502	221,001	1,809,503	-103	1,809,400	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315

Period:

Worksheet M-1

Component CCN: 14-3482

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:13 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	-15,196	515,304	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	401,981	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	270,579	9.00
10.00	Subtotal (sum of lines 1 through 9)	-15,196	1,187,864	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	-113,719	-7,225	13.00
14.00	Subtotal (sum of lines 11 through 13)	-113,719	-7,225	14.00
15.00	Medical Supplies	0	0	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	0	18.00
19.00	Other Health Care Costs	0	59,384	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	59,384	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-128,915	1,240,023	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	-4,052	48,503	25.01
25.02	Chronic Care Management	0	90,193	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)	-4,052	138,696	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	736	29.00
30.00	Administrative Costs	59,562	356,540	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,562	357,276	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-73,405	1,735,995	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315

Period:

Worksheet M-2

Component CCN: 14-3482

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/28/2022 9:13 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	1.55	3,208	4,200	6,510
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	2.90	6,734	2,100	6,090
4.00	Subtotal (sum of lines 1 through 3)	4.45	9,942	12,600	12,600
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)	4.45	9,942		12,600
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,240,023
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				138,696
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,378,719
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.899402
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				357,276
15.00	Parent provider overhead allocated to facility (see instructions)				1,688,835
16.00	Total overhead (sum of lines 14 and 15)				2,046,111
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				2,046,111
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,840,276
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,080,299

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/28/2022 9:13 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)			3,080,299	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			117,409	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,962,890	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,600	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)			12,600	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			235.15	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	230.93	8.00
9.00	Rate for Program covered visits (see instructions)	235.15	235.15	230.93	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	601	615	1,246	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	141,325	144,617	287,739	11.00
12.00	Program covered visits for mental health services (from contractor records)	1	0	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	235	0	462	13.00
14.00	Limit adjustment for mental health services (see instructions)	235	0	462	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	574,378		16.00
16.01	Total program charges (see instructions)(from contractor's records)		625,829		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		85,237		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,230		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.)		363,022		16.04
16.05	Total program cost (see instructions)	0	441,252		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,371		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		99,644		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		441,252		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,004		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		479,256		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		479,256		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		420,834		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)		58,422		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: 14-1315

Period:

Worksheet M-4

Component CCN: 14-3482

From 10/01/2020
To 09/30/2021Date/Time Prepared:
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		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,187,864	1,187,864	1,187,864	1,187,864	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000787	0.002422	0.002366	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	935	2,877	2,810	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	26,169	14,474	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	27,104	17,351	2,810	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,240,023	1,240,023	1,240,023	1,240,023	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,840,276	1,840,276	1,840,276	1,840,276	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.021858	0.013992	0.002266	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	40,225	25,749	4,170	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	67,329	43,100	6,980	0	10.00
11.00	Total number of injections/infusions (from your records)	181	557	272	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	371.98	77.38	25.66	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	56	146	180	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			49	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)	20,831	11,297	5,876	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)		117,409			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)		38,004			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/28/2022 9:13 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		420,834	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)		420,834	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		58,422	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		479,256	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00