

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: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/24/2022 9:58 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/24/2022	Time: 9:58 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Martin Adams	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	Martin Adams		2
3	Signatory Title	CFO		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	763,218	-89	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	224,658	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		122,525		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-34		0	10.01
10.02 RURAL HEALTH CLINIC III	0		-35,489		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		-176,566		0	10.03
10.04 RURAL HEALTH CLINIC V	0		-1,167		0	10.04
200.00 Total	0	987,876	-90,820	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: 14-1320		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 721 EAST COURT STREET			PO Box:				1.00	
2.00	City: PARIS			State: IL		Zip Code: 61944-		County: EDGAR 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N
4.00	Subprovider - IPF							O	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	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			FMC	143987	99914		09/24/1994	N
15.01	Hospital-Based Health Clinic - RHC			HATCH	143989	99914		01/01/1995	N
15.02	Hospital-Based Health Clinic - RHC			FMC OAKLAND	148596	99914		02/22/2019	N
15.03	Hospital-Based Health Clinic - RHC			EZ CARE - PARIS	148607	99914		09/25/2019	N
15.04	Hospital-Based Health Clinic - RHC			EZ CARE MARSHALL	148606	99914		11/14/2019	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)						01/01/2021	12/31/2021	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N			23.00	
		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
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
		Urban/Rural S				Date of Geogr	
		1.00				2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:				Ending:	
		1.00				2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	0				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 OPDS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N				Y/N	
		1.00				2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N				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				40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N				45.00	
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				46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N				47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				48.00	
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				56.00	
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.					57.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
			V 1.00	XVIII 2.00	XIX 3.00
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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
		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	
		1.00	2.00	3.00	
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
61.20	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
					1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N			63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/24/2022 9:58 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00	2.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	498,493		0		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
				3.00		4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 9:58 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 9:58 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/24/2022	N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Y 03/24/2022
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 9:58 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
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?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/24/2022 9:58 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 9:58 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	49,464.00	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	49,464.00	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	49,464.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 9:58 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)	1,223	24	2,061			1.00
2.00	HMO and other (see instructions)	341	142				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	529	0	753			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	948			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,752	24	3,762			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)	1,752	24	3,762	0.00	394.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	11,438	0	42,577	0.00	82.20	26.00
26.01	RURAL HEALTH CLINIC II	572	0	4,050	0.00	5.96	26.01
26.02	RURAL HEALTH CLINIC III	682	0	2,516	0.00	3.84	26.02
26.03	RURAL HEALTH CLINIC IV	2,232	0	19,188	0.00	23.33	26.03
26.04	RURAL HEALTH CLINIC V	496	0	5,271	0.00	5.22	26.04
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	514.60	27.00
28.00	Observation Bed Days		293	1,354			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 9:58 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	421	9	692	1.00
2.00 HMO and other (see instructions)			84	53		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	421	9	692	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
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		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-3987		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/24/2022 9:58 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					
	Street	727 EAST COURT STREET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	PARIS		IL 61944	2.00	
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
		Grant Award		Date		
		1.00		2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
					1.00	
					2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)						
11.00	CLINIC		08:00	17:00	08:00	11.00
					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					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-3987

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

Date/Time Prepared:

5/24/2022 9:58 am

RHC I

Cost

				County				
				4.00				
2.00	City, State, ZIP Code, County			EDGAR				2.00
			Tuesday	Wednesday		Thursday		
			to	from	to	from	to	
			6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)							
11.00	CLINIC		17:00	08:00	19:00	08:00	19:00	11.00
			Friday		Saturday			
			from	to	from	to		
			11.00	12.00	13.00	14.00		
	Facility hours of operations (1)							
11.00	CLINIC		08:00	19:00	08:00	11:30		11.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-3989		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/24/2022 9:58 am		
		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	144 ILLINOIS				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	CHRISMAN		IL 61924	2.00	
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0				3.00
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00	
		Sunday	Monday	Tuesday		
		from	to	from		
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	CLINIC	08:00	12:00	13:30	11.00	
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N		0	12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
		Total Visits				
		5.00				
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-3989

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

RHC II

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-8596		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/24/2022 9:58 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	721 EAST COURT ST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS IL 61944		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
CLINIC		08:00	17:00	08:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	EDGAR		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	Facility hours of operations (1)				
CLINIC		17:00	08:00	19:00	08:00
				19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-8596

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	19:00	08:00	11:30		11.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-8607		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/24/2022 9:58 am	
		RHC IV		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1 PHILLIPS LANE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS IL 61944		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	EDGAR		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	19:00	08:00
		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-8607

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

RHC IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	19:00	08:00	11:30		11.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-8606		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/24/2022 9:58 am	
		RHC V		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1602 NORTH IL HWY 1		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MARSHALL IL 62441		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
11.00	CLINIC	08:00	17:00	08:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	CLARK		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	Facility hours of operations (1)				
11.00	CLINIC	17:00	08:00	19:00	08:00
		19:00		11.00	

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1320	Period: From 01/01/2021	Worksheet S-8
			Component CCN: 14-8606	To 12/31/2021	Date/Time Prepared: 5/24/2022 9:58 am
			RHC V		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	19:00	08:00	11:30
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/24/2022 9:58 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)			0.500139 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	10,004,160		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	39,232,885		6.00
7.00	Medicaid cost (line 1 times line 6)	19,621,896		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)	9,617,736		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)	9,617,736		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,857,432	0	1,857,432 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	928,974	0	928,974 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)	928,974	0	928,974 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)	4,210,618		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	227,904		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	350,621		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,859,997		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,053,252		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,982,226		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,599,962		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

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

Worksheet A

Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,809,760	1,809,760	707,249	2,517,009	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,759,062	1,759,062	172,561	1,931,623	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	315,069	392,211	707,280	5,314,094	6,021,374	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,196,468	9,964,180	14,160,648	-5,573,770	8,586,878	5.01
5.02	00560	ADMITTING	1,572,507	2,034,343	3,606,850	-476	3,606,374	5.02
7.00	00700	OPERATION OF PLANT	742,093	1,250,598	1,992,691	-6,526	1,986,165	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,265	129,265	0	129,265	8.00
9.00	00900	HOUSEKEEPING	696,269	315,051	1,011,320	-142	1,011,178	9.00
10.00	01000	DIETARY	595,627	510,264	1,105,891	-848,930	256,961	10.00
11.00	01100	CAFETERIA	0	0	0	847,002	847,002	11.00
13.00	01300	NURSING ADMINISTRATION	442,045	71,218	513,263	0	513,263	13.00
15.00	01500	PHARMACY	335,023	3,690,862	4,025,885	-3,518,823	507,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536,901	110,451	647,352	0	647,352	16.00
17.00	01700	SOCIAL SERVICE	80,254	10,572	90,826	0	90,826	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,961,602	786,895	4,748,497	-35,834	4,712,663	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,191,329	3,331,758	5,523,087	-4,126,130	1,396,957	50.00
53.00	05300	ANESTHESIOLOGY	2,373,095	632,277	3,005,372	-290,247	2,715,125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,074,043	1,396,201	3,470,244	-235,373	3,234,871	54.00
60.00	06000	LABORATORY	979,816	2,594,854	3,574,670	-1,169,970	2,404,700	60.00
65.00	06500	RESPIRATORY THERAPY	707,250	245,829	953,079	-91,428	861,651	65.00
66.00	06600	PHYSICAL THERAPY	1,379,216	268,838	1,648,054	-1,952	1,646,102	66.00
69.00	06900	ELECTROCARDIOLOGY	0	84,221	84,221	79,770	163,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	771	771	0	771	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,272,755	4,272,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,789,096	1,789,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,654,484	3,654,484	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,889,255	3,578,928	11,468,183	0	11,468,183	88.00
88.01	08801	RURAL HEALTH CLINIC II	443,474	190,101	633,575	0	633,575	88.01
88.02	08802	RURAL HEALTH CLINIC III	603,523	165,171	768,694	0	768,694	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,194,204	1,084,233	3,278,437	0	3,278,437	88.03
88.04	08804	RURAL HEALTH CLINIC V	369,826	121,213	491,039	0	491,039	88.04
90.00	09000	CLINIC	529,191	261,053	790,244	-14,940	775,304	90.00
90.01	04951	CHEMO/PAIN	1,001,004	838,637	1,839,641	-343,690	1,495,951	90.01
90.02	09002	SENIOR CARE	44,726	554,502	599,228	-992	598,236	90.02
90.03	09003	SLEEP LAB	47,458	34,767	82,225	-246	81,979	90.03
90.04	09001	ORTHOPEDICS	2,219,252	363,096	2,582,348	-9,847	2,572,501	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	113,762	259,459	373,221	0	373,221	90.05
91.00	09100	EMERGENCY	2,204,801	2,097,946	4,302,747	-38,521	4,264,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,387,659	396,229	1,783,888	-9,719	1,774,169	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		519,455	519,455	-519,455	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,226,742	41,854,271	84,081,013	0	84,081,013	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341,135	388,180	729,315	0	729,315	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	379,779	87,516	467,295	0	467,295	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
200.00		TOTAL (SUM OF LINES 118 through 199)	42,947,656	42,329,967	85,277,623	0	85,277,623	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

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

Worksheet A

Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-29,432	2,487,577	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,931,623	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-244,804	5,776,570	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-568,055	8,018,823	5.01
5.02	00560	ADMITTING	0	3,606,374	5.02
7.00	00700	OPERATION OF PLANT	-1,434	1,984,731	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,265	8.00
9.00	00900	HOUSEKEEPING	-3	1,011,175	9.00
10.00	01000	DIETARY	-37,321	219,640	10.00
11.00	01100	CAFETERIA	-158,891	688,111	11.00
13.00	01300	NURSING ADMINISTRATION	-54	513,209	13.00
15.00	01500	PHARMACY	-4,370	502,692	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,480	643,872	16.00
17.00	01700	SOCIAL SERVICE	0	90,826	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-912,500	3,800,163	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-583	1,396,374	50.00
53.00	05300	ANESTHESIOLOGY	-2,119,047	596,078	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-657,620	2,577,251	54.00
60.00	06000	LABORATORY	-5,880	2,398,820	60.00
65.00	06500	RESPIRATORY THERAPY	-131	861,520	65.00
66.00	06600	PHYSICAL THERAPY	-8,337	1,637,765	66.00
69.00	06900	ELECTROCARDIOLOGY	-70,062	93,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-771	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,272,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,789,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-26,136	3,628,348	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-160,574	11,307,609	88.00
88.01	08801	RURAL HEALTH CLINIC II	-4,972	628,603	88.01
88.02	08802	RURAL HEALTH CLINIC III	-13,270	755,424	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-763	3,277,674	88.03
88.04	08804	RURAL HEALTH CLINIC V	-4,539	486,500	88.04
90.00	09000	CLINIC	-413,051	362,253	90.00
90.01	04951	CHEMO/PAIN	-262,132	1,233,819	90.01
90.02	09002	SENIOR CARE	-2,104	596,132	90.02
90.03	09003	SLEEP LAB	-12,815	69,164	90.03
90.04	09001	ORTHOPEDICS	-2,171,448	401,053	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	-250,115	123,106	90.05
91.00	09100	EMERGENCY	-1,249,889	3,014,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-20,870	1,753,299	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,415,453	74,665,560	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	729,315	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	192.01
192.02	19201	NAL CLINIC	0	467,295	192.02
192.03	19203	OAKLAND CLINIC	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	192.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,415,453	75,862,170	200.00

RECLASSIFICATIONS

Provider CCN: 14-1320

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

Worksheet A-6

Date/Time Prepared:
5/24/2022 9:58 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	172,561		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	0		0	172,561		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	456,191	390,811		1.00
	0		456,191	390,811		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	64,999	0		1.00
2.00		0.00	0	0		2.00
	0		64,999	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	187,794		1.00
	0		0	187,794		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,272,755		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	14,932		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	4,287,687		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,654,484		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	3,654,484		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	12,304	2,467		1.00
	0		12,304	2,467		
	J - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,789,096		1.00
	0		0	1,789,096		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	519,455		1.00
	0		0	519,455		

RECLASSIFICATIONS

Provider CCN: 14-1320

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

Worksheet A-6

Date/Time Prepared:
5/24/2022 9:58 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	L - BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,314,094	1.00
	0		0	5,314,094	
500.00	Grand Total: Increases		533,494	16,318,449	500.00

RECLASSIFICATIONS

Provider CCN: 14-1320

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

Worksheet A-6

Date/Time Prepared:
5/24/2022 9:58 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	86,797	10		1.00
2.00	ADMITTING	5.02	0	476	0		2.00
3.00	OPERATION OF PLANT	7.00	0	6,526	0		3.00
4.00	HOUSEKEEPING	9.00	0	12	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,688	0		5.00
6.00	OPERATING ROOM	50.00	0	61,050	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	543	0		7.00
8.00	LABORATORY	60.00	0	186	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	12,744	0		9.00
10.00	CHEMO/PAIN	90.01	0	271	0		10.00
11.00	SENIOR CARE	90.02	0	992	0		11.00
12.00	SLEEP LAB	90.03	0	246	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	30	0		13.00
	0		0	172,561			
	B - CAFETERIA						
1.00	DIETARY	10.00	456,191	390,811	0		1.00
	0		456,191	390,811			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	12,651	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	52,348	0	0		2.00
	0		64,999	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	187,794	12		1.00
	0		0	187,794			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	HOUSEKEEPING	9.00	0	130	0		1.00
2.00	DIETARY	10.00	0	1,918	0		2.00
3.00	PHARMACY	15.00	0	48,957	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	20,423	0		4.00
5.00	OPERATING ROOM	50.00	0	2,275,984	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	218,922	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	223,355	0		7.00
8.00	LABORATORY	60.00	0	1,169,784	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	25,086	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,473	0		10.00
11.00	CLINIC	90.00	0	155	0		11.00
12.00	CHEMO/PAIN	90.01	0	246,659	0		12.00
13.00	ORTHOPEDICS	90.04	0	9,847	0		13.00
14.00	EMERGENCY	91.00	0	37,812	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	7,182	0		15.00
	0		0	4,287,687			
	F - DRUGS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	17	0		1.00
2.00	DIETARY	10.00	0	10	0		2.00
3.00	PHARMACY	15.00	0	3,469,866	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	72	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	70,782	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,018	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	1,250	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	479	0		8.00
9.00	CLINIC	90.00	0	14	0		9.00
10.00	CHEMO/PAIN	90.01	0	96,760	0		10.00
11.00	EMERGENCY	91.00	0	709	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	2,507	0		12.00
	0		0	3,654,484			
	I - STRESS TEST						
1.00	CLINIC	90.00	12,304	2,467	0		1.00
	0		12,304	2,467			
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	1,789,096	0		1.00
	0		0	1,789,096			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	519,455	9		1.00
	0		0	519,455			
	L - BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5,314,094	0		1.00
	0		0	5,314,094			
500.00	Grand Total: Decreases		533,494	16,318,449			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/24/2022 9:58 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	501,832	1,125,000	0	1,125,000	0	1.00
2.00	Land Improvements	3,139,004	330,012	0	330,012	0	2.00
3.00	Buildings and Fixtures	49,686,296	2,968,835	0	2,968,835	0	3.00
4.00	Building Improvements	1,777,556	9,588,462	0	9,588,462	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	23,109,558	1,229,518	0	1,229,518	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,214,246	15,241,827	0	15,241,827	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,214,246	15,241,827	0	15,241,827	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,626,832	0				
2.00	Land Improvements	3,469,016	0				
3.00	Buildings and Fixtures	52,655,131	0				
4.00	Building Improvements	11,366,018	0				
5.00	Fixed Equipment	0	0				
6.00	Movable Equipment	24,339,076	0				
7.00	HIT designated Assets	0	0				
8.00	Subtotal (sum of lines 1-7)	93,456,073	0				
9.00	Reconciling Items	0	0				
10.00	Total (line 8 minus line 9)	93,456,073	0				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,744,856	0	0	64,904	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,759,062	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,503,918	0	0	64,904	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,809,760				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,759,062				2.00
3.00	Total (sum of lines 1-2)	0	3,568,822				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	69,116,997	0	69,116,997	0.739567	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	24,339,076	0	24,339,076	0.260433	0	2.00
3.00	Total (sum of lines 1-2)	93,456,073	0	93,456,073	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,234,879	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,759,062	172,561	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,993,941	172,561	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	252,698	0	0	2,487,577	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,931,623	2.00
3.00	Total (sum of lines 1-2)	0	252,698	0	0	4,419,200	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

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

Worksheet A-8

Date/Time Prepared:
5/24/2022 9:58 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		A	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-29,432	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-5,057	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-786	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	-6,126,212			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-158,891	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-199,486	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	B	-26,136	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,480	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

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

Worksheet A-8

Date/Time Prepared:
5/24/2022 9:58 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	EMPLOYEE BENEFITS DEPARTMENT-ADVERTI	A	-3,436	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	OTHER ADMINISTRATIVE AND GENERAL-ADV	A	-151,247	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.01
34.02	RADIOLOGY-DIAGNOSTIC-ADVERTISING	A	-11	RADIOLOGY-DIAGNOSTIC	54.00	0	34.02
34.03	RURAL HEALTH CLINIC-ADVERTISING	A	-135,983	RURAL HEALTH CLINIC	88.00	0	34.03
34.04	RURAL HEALTH CLINIC II-ADVERTISING	A	-4,966	RURAL HEALTH CLINIC II	88.01	0	34.04
34.05	RURAL HEALTH CLINIC III-ADVERTISING	A	-5,470	RURAL HEALTH CLINIC III	88.02	0	34.05
34.06	RURAL HEALTH CLINIC IV-ADVERTISING	A	-750	RURAL HEALTH CLINIC IV	88.03	0	34.06
34.07	RURAL HEALTH CLINIC V-ADVERTISING	A	-4,513	RURAL HEALTH CLINIC V	88.04	0	34.07
34.08	SENIOR CARE-ADVERTISING	A	-2,072	SENIOR CARE	90.02	0	34.08
34.09	ORTHOPEDICS-ADVERTISING	A	-22	ORTHOPEDICS	90.04	0	34.09
34.10	OTHER ADMINISTRATIVE AND GENERAL-NON	A	-8,817	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.10
34.11	CLINIC-NON- ALLOWABLE PHYS RECRUITME	A	-50,925	CLINIC	90.00	0	34.11
34.12	ANESTHESIA	A	-1,748,012	ANESTHESIOLOGY	53.00	0	34.12
35.00	ANESTHESIA BENEFITS	A	-137,393	ANESTHESIOLOGY	53.00	0	35.00
36.00	ANESTHESIA BENEFITS	A	-241,064	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	EMPLOYEE BENEFITS DEPARTMENT-OTHER R	B	-304	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	OTHER ADMINISTRATIVE AND GENERAL-OTH	B	-180,069	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	37.00
37.01	OPERATION OF PLANT-OTHER REVEUNUE	B	-1,434	OPERATION OF PLANT	7.00	0	37.01
37.02	HOUSEKEEPING-OTHER REVEUNUE	B	-3	HOUSEKEEPING	9.00	0	37.02
37.03	DIETARY-OTHER REVEUNUE	B	-37,321	DIETARY	10.00	0	37.03
37.04	NURSING ADMINISTRATION-OTHER REVEUNU	B	-54	NURSING ADMINISTRATION	13.00	0	37.04
37.05	PHARMACY-OTHER REVEUNUE	B	-4,370	PHARMACY	15.00	0	37.05
37.06	ADULTS & PEDIATRICS-OTHER REVEUNUE	B	-49,667	ADULTS & PEDIATRICS	30.00	0	37.06
37.07	OPERATING ROOM-OTHER REVEUNUE	B	-583	OPERATING ROOM	50.00	0	37.07
37.08	ANESTHESIOLOGY-OTHER REVEUNUE	B	-69	ANESTHESIOLOGY	53.00	0	37.08
37.09	RADIOLOGY-DIAGNOSTIC-OTHER REVEUNUE	B	-39	RADIOLOGY-DIAGNOSTIC	54.00	0	37.09
37.10	LABORATORY-OTHER REVEUNUE	B	-5,880	LABORATORY	60.00	0	37.10
37.11	RESPIRATORY THERAPY-OTHER REVEUNUE	B	-131	RESPIRATORY THERAPY	65.00	0	37.11
37.12	PHYSICAL THERAPY-OTHER REVEUNUE	B	-8,337	PHYSICAL THERAPY	66.00	0	37.12
37.13	ELECTROCARDIOLOGY-OTHER REVEUNUE	B	-11	ELECTROCARDIOLOGY	69.00	0	37.13
37.14	RURAL HEALTH CLINIC-OTHER REVEUNUE	B	-24,591	RURAL HEALTH CLINIC	88.00	0	37.14
37.15	RURAL HEALTH CLINIC II-OTHER REVEUNU	B	-6	RURAL HEALTH CLINIC II	88.01	0	37.15
37.16	RURAL HEALTH CLINIC III-OTHER REVEUN	B	-7,800	RURAL HEALTH CLINIC III	88.02	0	37.16
37.17	RURAL HEALTH CLINIC IV-OTHER REVEUNU	B	-13	RURAL HEALTH CLINIC IV	88.03	0	37.17
37.18	RURAL HEALTH CLINIC V-OTHER REVEUNUE	B	-26	RURAL HEALTH CLINIC V	88.04	0	37.18
37.19	CLINIC-OTHER REVEUNUE	B	-14	CLINIC	90.00	0	37.19
37.20	CHEMO/PAIN-OTHER REVEUNUE	B	-14,425	CHEMO/PAIN	90.01	0	37.20
37.21	SENIOR CARE-OTHER REVEUNUE	B	-32	SENIOR CARE	90.02	0	37.21
37.22	ORTHOPEDICS-OTHER REVEUNUE	B	-1,049	ORTHOPEDICS	90.04	0	37.22
37.23	BEHAVIORAL HEALTH CLINIC-OTHER REVEU	B	-5	BEHAVIORAL HEALTH CLINIC	90.05	0	37.23
37.24	EMERGENCY-OTHER REVEUNUE	B	-168	EMERGENCY	91.00	0	37.24

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

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

Worksheet A-8

Date/Time Prepared:
5/24/2022 9:58 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	
37.25	AMBULANCE SERVICES-OTHER REVENUE	B	-20,870	AMBULANCE SERVICES	95.00	0	37.25
37.26	LOBBYING DUES	A	-14,021	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	37.26
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,415,453				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1320

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2022 9:58 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	5.01	OTHER ADMINISTRATIVE AND GENERAL	328,096	8,572	319,524	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	874,833	862,833	12,000	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	248,958	233,573	15,385	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	657,570	657,570	0	0	0	4.00
5.00	60.00	LABORATORY	70,000	0	70,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	14,400	0	14,400	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	82,051	70,051	12,000	0	0	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	771	771	0	0	0	8.00
9.00	90.00	CLINIC	371,112	362,112	9,000	0	0	9.00
10.00	90.01	CHEMO/PAIN	259,707	247,707	12,000	0	0	10.00
11.00	90.02	SENIOR CARE	34,650	0	34,650	0	0	11.00
12.00	90.03	SLEEP LAB	16,815	12,815	4,000	0	0	12.00
13.00	90.04	ORTHOPEDICS	2,170,377	2,170,377	0	0	0	13.00
14.00	90.05	BEHAVIORAL HEALTH CLINIC	250,110	250,110	0	0	0	14.00
15.00	91.00	EMERGENCY	2,232,137	1,249,721	982,416	0	0	15.00
200.00			7,611,587	6,126,212	1,485,375		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.01	CHEMO/PAIN	0	0	0	0	0	10.00
11.00	90.02	SENIOR CARE	0	0	0	0	0	11.00
12.00	90.03	SLEEP LAB	0	0	0	0	0	12.00
13.00	90.04	ORTHOPEDICS	0	0	0	0	0	13.00
14.00	90.05	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	8,572		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	862,833		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	233,573		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	657,570		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	70,051		7.00
8.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	771		8.00
9.00	90.00	CLINIC	0	0	0	362,112		9.00
10.00	90.01	CHEMO/PAIN	0	0	0	247,707		10.00
11.00	90.02	SENIOR CARE	0	0	0	0		11.00
12.00	90.03	SLEEP LAB	0	0	0	12,815		12.00
13.00	90.04	ORTHOPEDICS	0	0	0	2,170,377		13.00
14.00	90.05	BEHAVIORAL HEALTH CLINIC	0	0	0	250,110		14.00
15.00	91.00	EMERGENCY	0	0	0	1,249,721		15.00
200.00			0	0	0	6,126,212		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,487,577	2,487,577			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,931,623		1,931,623		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,776,570	16,683	12,955	5,806,208	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	8,018,823	367,729	285,545	850,068	5.01
5.02	00560	ADMITTING	3,606,374	59,210	45,977	318,535	5.02
7.00	00700	OPERATION OF PLANT	1,984,731	213,460	165,754	150,322	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,265	17,475	13,569	0	8.00
9.00	00900	HOUSEKEEPING	1,011,175	12,292	9,545	141,040	9.00
10.00	01000	DIETARY	219,640	55,214	42,874	28,245	10.00
11.00	01100	CAFETERIA	688,111	25,124	19,509	92,408	11.00
13.00	01300	NURSING ADMINISTRATION	513,209	24,836	19,285	89,543	13.00
15.00	01500	PHARMACY	502,692	15,675	12,172	67,864	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	643,872	40,151	31,178	108,757	16.00
17.00	01700	SOCIAL SERVICE	90,826	2,808	2,180	16,257	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,800,163	252,064	195,729	799,919	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,396,374	253,234	196,638	443,887	50.00
53.00	05300	ANESTHESIOLOGY	596,078	2,142	1,663	126,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,577,251	132,547	102,924	420,129	54.00
60.00	06000	LABORATORY	2,398,820	55,232	42,888	198,476	60.00
65.00	06500	RESPIRATORY THERAPY	861,520	6,857	5,324	132,660	65.00
66.00	06600	PHYSICAL THERAPY	1,637,765	421,250	327,104	279,381	66.00
69.00	06900	ELECTROCARDIOLOGY	93,929	9,430	7,323	15,659	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,272,755	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,789,096	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,628,348	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,307,609	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	628,603	26,995	20,962	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	755,424	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,277,674	196,220	152,366	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	486,500	28,633	22,234	0	88.04
90.00	09000	CLINIC	362,253	11,068	8,594	104,703	90.00
90.01	04951	CHEMO/PAIN	1,233,819	27,787	21,577	202,768	90.01
90.02	09002	SENIOR CARE	596,132	0	0	9,060	90.02
90.03	09003	SLEEP LAB	69,164	2,340	1,817	9,613	90.03
90.04	09001	ORTHOPEDICS	401,053	33,168	25,755	449,543	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	123,106	7,703	5,981	23,044	90.05
91.00	09100	EMERGENCY	3,014,337	92,756	72,026	446,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,753,299	0	0	281,091	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,665,560	2,410,083	1,871,448	5,806,208	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	729,315	38,243	29,696	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	467,295	39,251	30,479	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	75,862,170	2,487,577	1,931,623	5,806,208	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	9,522,165					5.01
5.02	00560	ADMITTING	578,464	4,608,560				5.02
7.00	00700	OPERATION OF PLANT	360,888	0	2,875,155			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,010	0	31,827	215,146		8.00
9.00	00900	HOUSEKEEPING	168,519	0	22,387	0	1,364,958	9.00
10.00	01000	DIETARY	49,660	0	100,561	0	48,658	10.00
11.00	01100	CAFETERIA	118,439	0	45,757	0	22,140	11.00
13.00	01300	NURSING ADMINISTRATION	92,850	0	45,233	0	21,887	13.00
15.00	01500	PHARMACY	85,892	0	28,549	0	13,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118,268	0	73,126	0	35,383	16.00
17.00	01700	SOCIAL SERVICE	16,086	0	5,113	0	2,474	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	724,552	701,199	459,078	215,146	222,132	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	328,717	311,672	461,209	0	223,163	50.00
53.00	05300	ANESTHESIOLOGY	104,279	0	3,900	0	1,887	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	464,031	456,422	241,404	0	116,807	54.00
60.00	06000	LABORATORY	386,889	392,641	100,593	0	48,674	60.00
65.00	06500	RESPIRATORY THERAPY	144,449	141,931	12,488	0	6,043	65.00
66.00	06600	PHYSICAL THERAPY	382,595	381,662	767,218	0	371,230	66.00
69.00	06900	ELECTROCARDIOLOGY	18,134	17,898	17,175	0	8,311	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	613,294	647,481	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	256,800	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	520,799	549,830	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,623,033	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	97,111	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	108,431	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	520,499	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	77,132	0	0	0	0	88.04
90.00	09000	CLINIC	69,847	65,398	20,158	0	9,754	90.00
90.01	04951	CHEMO/PAIN	213,287	209,021	50,608	0	24,488	90.01
90.02	09002	SENIOR CARE	86,867	90,987	0	0	0	90.02
90.03	09003	SLEEP LAB	11,904	11,802	4,261	0	2,062	90.03
90.04	09001	ORTHOPEDICS	130,549	102,007	60,408	0	29,230	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	22,942	22,385	14,029	0	6,788	90.05
91.00	09100	EMERGENCY	520,423	506,224	168,934	0	81,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	292,008	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,330,648	4,608,560	2,734,016	215,146	1,296,666	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,435	0	69,652	0	33,702	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	77,082	0	71,487	0	34,590	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	9,522,165	4,608,560	2,875,155	215,146	1,364,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	544,852					10.00
11.00	01100	CAFETERIA	0	1,011,488				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,434	828,277			13.00
15.00	01500	PHARMACY	0	16,245	0	742,903		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,033	0	0	1,076,768	16.00
17.00	01700	SOCIAL SERVICE	0	3,891	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	544,852	191,486	335,225	0	31,466	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	106,253	179,066	0	153,471	50.00
53.00	05300	ANESTHESIOLOGY	0	30,309	0	0	21,944	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,566	0	0	288,460	54.00
60.00	06000	LABORATORY	0	47,509	0	0	187,064	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,755	0	0	8,972	65.00
66.00	06600	PHYSICAL THERAPY	0	66,875	0	0	86,322	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,748	0	0	18,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	73	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	51,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	22,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	742,903	110,257	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	25,063	0	0	1,922	90.00
90.01	04951	CHEMO/PAIN	0	48,537	68,548	0	13,780	90.01
90.02	09002	SENIOR CARE	0	2,169	3,778	0	4,096	90.02
90.03	09003	SLEEP LAB	0	2,301	0	0	1,085	90.03
90.04	09001	ORTHOPEDICS	0	107,607	0	0	7,361	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	5,516	0	0	1,328	90.05
91.00	09100	EMERGENCY	0	106,906	127,027	0	67,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	67,285	114,633	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,852	1,011,488	828,277	742,903	1,076,768	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	544,852	1,011,488	828,277	742,903	1,076,768	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING					5.02
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	139,635				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	139,635	8,612,646	0	8,612,646	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,053,684	0	4,053,684	50.00
53.00	05300	ANESTHESIOLOGY	0	888,822	0	888,822	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,900,541	0	4,900,541	54.00
60.00	06000	LABORATORY	0	3,858,786	0	3,858,786	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,351,999	0	1,351,999	65.00
66.00	06600	PHYSICAL THERAPY	0	4,721,402	0	4,721,402	66.00
69.00	06900	ELECTROCARDIOLOGY	0	209,884	0	209,884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	73	0	73	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,584,957	0	5,584,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,068,302	0	2,068,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,552,137	0	5,552,137	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	12,930,642	0	12,930,642	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	773,671	0	773,671	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	863,855	0	863,855	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	4,146,759	0	4,146,759	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	614,499	0	614,499	88.04
90.00	09000	CLINIC	0	678,760	0	678,760	90.00
90.01	04951	CHEMO/PAIN	0	2,114,220	0	2,114,220	90.01
90.02	09002	SENIOR CARE	0	793,089	0	793,089	90.02
90.03	09003	SLEEP LAB	0	116,349	0	116,349	90.03
90.04	09001	ORTHOPEDICS	0	1,346,681	0	1,346,681	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	232,822	0	232,822	90.05
91.00	09100	EMERGENCY	0	5,204,047	0	5,204,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,508,316	0	2,508,316	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	139,635	74,126,943	0	74,126,943	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,015,043	0	1,015,043	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	720,184	0	720,184	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	139,635	75,862,170	0	75,862,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,683	12,955	29,638	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	367,729	285,545	653,274	5.01
5.02	00560	ADMITTING	0	59,210	45,977	105,187	5.02
7.00	00700	OPERATION OF PLANT	0	213,460	165,754	379,214	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,475	13,569	31,044	8.00
9.00	00900	HOUSEKEEPING	0	12,292	9,545	21,837	9.00
10.00	01000	DIETARY	0	55,214	42,874	98,088	10.00
11.00	01100	CAFETERIA	0	25,124	19,509	44,633	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,836	19,285	44,121	13.00
15.00	01500	PHARMACY	0	15,675	12,172	27,847	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,151	31,178	71,329	16.00
17.00	01700	SOCIAL SERVICE	0	2,808	2,180	4,988	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	252,064	195,729	447,793	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	253,234	196,638	449,872	50.00
53.00	05300	ANESTHESIOLOGY	0	2,142	1,663	3,805	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,547	102,924	235,471	54.00
60.00	06000	LABORATORY	0	55,232	42,888	98,120	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,857	5,324	12,181	65.00
66.00	06600	PHYSICAL THERAPY	0	421,250	327,104	748,354	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,430	7,323	16,753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	26,995	20,962	47,957	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	196,220	152,366	348,586	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	28,633	22,234	50,867	88.04
90.00	09000	CLINIC	0	11,068	8,594	19,662	90.00
90.01	04951	CHEMO/PAIN	0	27,787	21,577	49,364	90.01
90.02	09002	SENIOR CARE	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	2,340	1,817	4,157	90.03
90.04	09001	ORTHOPEDICS	0	33,168	25,755	58,923	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	7,703	5,981	13,684	90.05
91.00	09100	EMERGENCY	0	92,756	72,026	164,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,410,083	1,871,448	4,281,531	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,243	29,696	67,939	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	39,251	30,479	69,730	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
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)	0	2,487,577	1,931,623	4,419,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	657,614				5.01
5.02	00560	ADMITTING	39,950	146,763			5.02
7.00	00700	OPERATION OF PLANT	24,924	0	404,905		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,589	0	4,482	37,115	8.00
9.00	00900	HOUSEKEEPING	11,638	0	3,153	0	9.00
10.00	01000	DIETARY	3,430	0	14,162	0	10.00
11.00	01100	CAFETERIA	8,180	0	6,444	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,412	0	6,370	0	13.00
15.00	01500	PHARMACY	5,932	0	4,021	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,168	0	10,298	0	16.00
17.00	01700	SOCIAL SERVICE	1,111	0	720	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	50,040	22,326	64,651	37,115	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,702	9,926	64,952	0	50.00
53.00	05300	ANESTHESIOLOGY	7,202	0	549	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,047	14,535	33,997	0	54.00
60.00	06000	LABORATORY	26,720	12,504	14,166	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,976	4,520	1,759	0	65.00
66.00	06600	PHYSICAL THERAPY	26,423	12,155	108,046	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,252	570	2,419	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,356	20,620	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,735	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,968	17,510	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	112,078	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,707	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,489	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	35,947	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	5,327	0	0	0	88.04
90.00	09000	CLINIC	4,824	2,083	2,839	0	90.00
90.01	04951	CHEMO/PAIN	14,730	6,657	7,127	0	90.01
90.02	09002	SENIOR CARE	5,999	2,898	0	0	90.02
90.03	09003	SLEEP LAB	822	376	600	0	90.03
90.04	09001	ORTHOPEDICS	9,016	3,249	8,507	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	1,584	713	1,976	0	90.05
91.00	09100	EMERGENCY	35,942	16,121	23,791	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				2,237	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	20,167	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	644,387	146,763	385,029	37,115	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,903	0	9,809	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	5,324	0	10,067	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	657,614	146,763	404,905	37,115	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	117,155					10.00
11.00	01100	CAFETERIA	0	60,335				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,278	59,237			13.00
15.00	01500	PHARMACY	0	969	0	39,493		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,553	0	0	92,871	16.00
17.00	01700	SOCIAL SERVICE	0	232	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	117,155	11,427	23,977	0	2,713	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,337	12,806	0	13,230	50.00
53.00	05300	ANESTHESIOLOGY	0	1,808	0	0	1,892	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,998	0	0	24,912	54.00
60.00	06000	LABORATORY	0	2,834	0	0	16,126	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,894	0	0	773	65.00
66.00	06600	PHYSICAL THERAPY	0	3,989	0	0	7,442	66.00
69.00	06900	ELECTROCARDIOLOGY	0	224	0	0	1,576	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,493	9,505	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	1,495	0	0	166	90.00
90.01	04951	CHEMO/PAIN	0	2,895	4,902	0	1,188	90.01
90.02	09002	SENIOR CARE	0	129	270	0	353	90.02
90.03	09003	SLEEP LAB	0	137	0	0	93	90.03
90.04	09001	ORTHOPEDICS	0	6,418	0	0	635	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	329	0	0	115	90.05
91.00	09100	EMERGENCY	0	6,376	9,084	0	5,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	4,013	8,198	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,155	60,335	59,237	39,493	92,871	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	117,155	60,335	59,237	39,493	92,871	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING					5.02
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	7,202				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,202	794,560	0	794,560	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	588,197	0	588,197	50.00
53.00	05300	ANESTHESIOLOGY	0	15,954	0	15,954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	352,301	0	352,301	54.00
60.00	06000	LABORATORY	0	172,815	0	172,815	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,945	0	31,945	65.00
66.00	06600	PHYSICAL THERAPY	0	917,993	0	917,993	66.00
69.00	06900	ELECTROCARDIOLOGY	0	23,101	0	23,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,409	0	67,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,667	0	19,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,476	0	102,476	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	112,078	0	112,078	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	54,664	0	54,664	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,489	0	7,489	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	384,533	0	384,533	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	56,194	0	56,194	88.04
90.00	09000	CLINIC	0	31,870	0	31,870	90.00
90.01	04951	CHEMO/PAIN	0	88,568	0	88,568	90.01
90.02	09002	SENIOR CARE	0	9,695	0	9,695	90.02
90.03	09003	SLEEP LAB	0	6,290	0	6,290	90.03
90.04	09001	ORTHOPEDICS	0	89,843	0	89,843	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	18,705	0	18,705	90.05
91.00	09100	EMERGENCY	0	266,394	0	266,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	33,813	0	33,813	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,202	4,246,560	0	4,246,560	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,573	0	86,573	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	86,067	0	86,067	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
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)	7,202	4,419,200	0	4,419,200	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1320

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	138,223				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		138,223			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	28,663,379		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	4,196,468	-9,522,165	5.01
5.02	00560	ADMITTING	3,290	3,290	1,572,507	0	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	742,093	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	8.00
9.00	00900	HOUSEKEEPING	683	683	696,269	0	9.00
10.00	01000	DIETARY	3,068	3,068	139,436	0	10.00
11.00	01100	CAFETERIA	1,396	1,396	456,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	442,045	0	13.00
15.00	01500	PHARMACY	871	871	335,023	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	536,901	0	16.00
17.00	01700	SOCIAL SERVICE	156	156	80,254	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	3,948,951	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,071	14,071	2,191,329	0	50.00
53.00	05300	ANESTHESIOLOGY	119	119	625,083	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	2,074,043	0	54.00
60.00	06000	LABORATORY	3,069	3,069	979,816	0	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	654,902	0	65.00
66.00	06600	PHYSICAL THERAPY	23,407	23,407	1,379,216	0	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	77,303	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,500	1,500	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,903	10,903	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,591	1,591	0	0	88.04
90.00	09000	CLINIC	615	615	516,887	0	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	1,001,004	0	90.01
90.02	09002	SENIOR CARE	0	0	44,726	0	90.02
90.03	09003	SLEEP LAB	130	130	47,458	0	90.03
90.04	09001	ORTHOPEDICS	1,843	1,843	2,219,252	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	428	428	113,762	0	90.05
91.00	09100	EMERGENCY	5,154	5,154	2,204,801	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	1,387,659	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,917	133,917	28,663,379	-9,522,165	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,125	2,125	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	2,181	2,181	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
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)	2,487,577	1,931,623	5,806,208	9,522,165	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.996838	13.974686	0.202565	0.143536	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			29,638	657,614	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001034	0.009913	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: 14-1320

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING	34,745,944				5.02
7.00	00700	OPERATION OF PLANT	0	87,718			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100		8.00
9.00	00900	HOUSEKEEPING	0	683	0	86,064	9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100 10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0 13.00
15.00	01500	PHARMACY	0	871	0	871	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0 16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,286,681	14,006	100	14,006	100 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,349,829	14,071	0	14,071	0 50.00
53.00	05300	ANESTHESIOLOGY	0	119	0	119	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,441,160	7,365	0	7,365	0 54.00
60.00	06000	LABORATORY	2,960,293	3,069	0	3,069	0 60.00
65.00	06500	RESPIRATORY THERAPY	1,070,078	381	0	381	0 65.00
66.00	06600	PHYSICAL THERAPY	2,877,512	23,407	0	23,407	0 66.00
69.00	06900	ELECTROCARDIOLOGY	134,938	524	0	524	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,881,640	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,145,402	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0 88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0 88.04
90.00	09000	CLINIC	493,065	615	0	615	0 90.00
90.01	04951	CHEMO/PAIN	1,575,896	1,544	0	1,544	0 90.01
90.02	09002	SENIOR CARE	685,991	0	0	0	0 90.02
90.03	09003	SLEEP LAB	88,978	130	0	130	0 90.03
90.04	09001	ORTHOPEDICS	769,074	1,843	0	1,843	0 90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	168,768	428	0	428	0 90.05
91.00	09100	EMERGENCY	3,816,639	5,154	0	5,154	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,745,944	83,412	100	81,758	100 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,125	0	2,125	0 192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 192.01
192.02	19201	NAL CLINIC	0	2,181	0	2,181	0 192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0 192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0 192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0 192.05
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)	4,608,560	2,875,155	215,146	1,364,958	544,852 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.132636	32.777252	2,151.460000	15.859802	5,448.520000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	146,763	404,905	37,115	37,348	117,155 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004224	4.615985	371.150000	0.433956	1,171.550000 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: 14-1320

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

Worksheet B-1

Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	20,860,415					11.00
13.00	01300	NURSING ADMINISTRATION	442,045	9,805,190				13.00
15.00	01500	PHARMACY	335,023	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536,901	0	0	130,741,447		16.00
17.00	01700	SOCIAL SERVICE	80,254	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,948,951	3,968,376	0	3,820,601	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,191,329	2,119,806	0	18,634,145	0	50.00
53.00	05300	ANESTHESIOLOGY	625,083	0	0	2,664,398	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,074,043	0	0	35,026,514	0	54.00
60.00	06000	LABORATORY	979,816	0	0	22,712,932	0	60.00
65.00	06500	RESPIRATORY THERAPY	654,902	0	0	1,089,387	0	65.00
66.00	06600	PHYSICAL THERAPY	1,379,216	0	0	10,481,072	0	66.00
69.00	06900	ELECTROCARDIOLOGY	77,303	0	0	2,219,102	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,841	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,244,114	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,720,543	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	13,387,209	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	516,887	0	0	233,388	0	90.00
90.01	04951	CHEMO/PAIN	1,001,004	811,484	0	1,673,157	0	90.01
90.02	09002	SENIOR CARE	44,726	44,726	0	497,341	0	90.02
90.03	09003	SLEEP LAB	47,458	0	0	131,690	0	90.03
90.04	09001	ORTHOPEDICS	2,219,252	0	0	893,780	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	113,762	0	0	161,285	0	90.05
91.00	09100	EMERGENCY	2,204,801	1,503,759	0	8,141,948	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,387,659	1,357,039	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,860,415	9,805,190	100	130,741,447	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	1,011,488	828,277	742,903	1,076,768	139,635	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.048488	0.084473	7,429.030000	0.008236	1,396.350000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,335	59,237	39,493	92,871	7,202	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002892	0.006041	394.930000	0.000710	72.020000	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: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 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	8,612,646		8,612,646	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,053,684		4,053,684	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	888,822		888,822	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,900,541		4,900,541	0	0	54.00	
60.00	06000	LABORATORY	3,858,786		3,858,786	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1,351,999	0	1,351,999	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	4,721,402	0	4,721,402	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	209,884		209,884	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	73		73	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,584,957		5,584,957	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,068,302		2,068,302	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,552,137		5,552,137	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	12,930,642		12,930,642	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	773,671		773,671	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	863,855		863,855	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	4,146,759		4,146,759	0	0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	614,499		614,499	0	0	88.04	
90.00	09000	CLINIC	678,760		678,760	0	0	90.00	
90.01	04951	CHEMO/PAIN	2,114,220		2,114,220	0	0	90.01	
90.02	09002	SENIOR CARE	793,089		793,089	0	0	90.02	
90.03	09003	SLEEP LAB	116,349		116,349	0	0	90.03	
90.04	09001	ORTHOPEDICS	1,346,681		1,346,681	0	0	90.04	
90.05	09004	BEHAVIORAL HEALTH CLINIC	232,822		232,822	0	0	90.05	
91.00	09100	EMERGENCY	5,204,047		5,204,047	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,786,965		2,786,965	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,508,316		2,508,316	0	0	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	76,913,908	0	76,913,908	0	0	200.00	
201.00		Less Observation Beds	2,786,965		2,786,965			201.00	
202.00		Total (see instructions)	74,126,943	0	74,126,943	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 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	9.00	10.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,499,588		2,499,588			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,184,422	15,449,723	18,634,145	0.217541	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	362,003	2,302,395	2,664,398	0.333592	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,038	33,848,476	35,026,514	0.139909	0.000000	54.00
60.00	06000	LABORATORY	1,844,211	20,868,721	22,712,932	0.169894	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	358,903	730,484	1,089,387	1.241064	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	828,187	9,652,885	10,481,072	0.450469	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	66,853	2,152,249	2,219,102	0.094581	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,841	8,841	0.008257	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	959,528	5,284,586	6,244,114	0.894435	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,141,196	1,579,347	2,720,543	0.760253	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,443,852	10,943,357	13,387,209	0.414734	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	353	8,624,374	8,624,727			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	813,843	813,843			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	485,021	485,021			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	4,001,303	4,001,303			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,124,181	1,124,181			88.04
90.00	09000	CLINIC	0	233,388	233,388	2.908290	0.000000	90.00
90.01	04951	CHEMO/PAIN	1,215	1,671,942	1,673,157	1.263611	0.000000	90.01
90.02	09002	SENIOR CARE	0	497,341	497,341	1.594658	0.000000	90.02
90.03	09003	SLEEP LAB	0	131,690	131,690	0.883507	0.000000	90.03
90.04	09001	ORTHOPEDICS	0	893,779	893,779	1.506727	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	161,285	161,285	1.443544	0.000000	90.05
91.00	09100	EMERGENCY	10,445	8,131,503	8,141,948	0.639165	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,530	1,259,483	1,321,013	2.109718	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,422,309	2,422,309	1.035506	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,940,324	133,272,506	148,212,830			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,940,324	133,272,506	148,212,830			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
88.03	08803 RURAL HEALTH CLINIC IV				88.03
88.04	08804 RURAL HEALTH CLINIC V				88.04
90.00	09000 CLINIC	0.000000			90.00
90.01	04951 CHEMO/PAIN	0.000000			90.01
90.02	09002 SENIOR CARE	0.000000			90.02
90.03	09003 SLEEP LAB	0.000000			90.03
90.04	09001 ORTHOPEDICS	0.000000			90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	0.000000			90.05
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 am

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8,612,646		8,612,646	0	8,612,646 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,053,684		4,053,684	0	4,053,684 50.00
53.00	05300 ANESTHESIOLOGY	888,822		888,822	0	888,822 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,900,541		4,900,541	0	4,900,541 54.00
60.00	06000 LABORATORY	3,858,786		3,858,786	0	3,858,786 60.00
65.00	06500 RESPIRATORY THERAPY	1,351,999	0	1,351,999	0	1,351,999 65.00
66.00	06600 PHYSICAL THERAPY	4,721,402	0	4,721,402	0	4,721,402 66.00
69.00	06900 ELECTROCARDIOLOGY	209,884		209,884	0	209,884 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	73		73	0	73 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,584,957		5,584,957	0	5,584,957 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,068,302		2,068,302	0	2,068,302 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,552,137		5,552,137	0	5,552,137 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	12,930,642		12,930,642	0	12,930,642 88.00
88.01	08801 RURAL HEALTH CLINIC II	773,671		773,671	0	773,671 88.01
88.02	08802 RURAL HEALTH CLINIC III	863,855		863,855	0	863,855 88.02
88.03	08803 RURAL HEALTH CLINIC IV	4,146,759		4,146,759	0	4,146,759 88.03
88.04	08804 RURAL HEALTH CLINIC V	614,499		614,499	0	614,499 88.04
90.00	09000 CLINIC	678,760		678,760	0	678,760 90.00
90.01	04951 CHEMO/PAIN	2,114,220		2,114,220	0	2,114,220 90.01
90.02	09002 SENIOR CARE	793,089		793,089	0	793,089 90.02
90.03	09003 SLEEP LAB	116,349		116,349	0	116,349 90.03
90.04	09001 ORTHOPEDICS	1,346,681		1,346,681	0	1,346,681 90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	232,822		232,822	0	232,822 90.05
91.00	09100 EMERGENCY	5,204,047		5,204,047	0	5,204,047 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,786,965		2,786,965	0	2,786,965 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,508,316		2,508,316	0	2,508,316 95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	76,913,908	0	76,913,908	0	76,913,908 200.00
201.00	Less Observation Beds	2,786,965		2,786,965		2,786,965 201.00
202.00	Total (see instructions)	74,126,943	0	74,126,943	0	74,126,943 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,499,588		2,499,588		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,184,422	15,449,723	18,634,145	0.217541	0.000000
53.00	05300	ANESTHESIOLOGY	362,003	2,302,395	2,664,398	0.333592	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,038	33,848,476	35,026,514	0.139909	0.000000
60.00	06000	LABORATORY	1,844,211	20,868,721	22,712,932	0.169894	0.000000
65.00	06500	RESPIRATORY THERAPY	358,903	730,484	1,089,387	1.241064	0.000000
66.00	06600	PHYSICAL THERAPY	828,187	9,652,885	10,481,072	0.450469	0.000000
69.00	06900	ELECTROCARDIOLOGY	66,853	2,152,249	2,219,102	0.094581	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,841	8,841	0.008257	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	959,528	5,284,586	6,244,114	0.894435	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,141,196	1,579,347	2,720,543	0.760253	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,443,852	10,943,357	13,387,209	0.414734	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	353	8,624,374	8,624,727	1.499252	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	813,843	813,843	0.950639	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	485,021	485,021	1.781067	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	4,001,303	4,001,303	1.036352	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	1,124,181	1,124,181	0.546619	0.000000
90.00	09000	CLINIC	0	233,388	233,388	2.908290	0.000000
90.01	04951	CHEMO/PAIN	1,215	1,671,942	1,673,157	1.263611	0.000000
90.02	09002	SENIOR CARE	0	497,341	497,341	1.594658	0.000000
90.03	09003	SLEEP LAB	0	131,690	131,690	0.883507	0.000000
90.04	09001	ORTHOPEDICS	0	893,779	893,779	1.506727	0.000000
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	161,285	161,285	1.443544	0.000000
91.00	09100	EMERGENCY	10,445	8,131,503	8,141,948	0.639165	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,530	1,259,483	1,321,013	2.109718	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,422,309	2,422,309	1.035506	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	14,940,324	133,272,506	148,212,830		
201.00		Less Observation Beds					
202.00		Total (see instructions)	14,940,324	133,272,506	148,212,830		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000			88.04
90.00	09000 CLINIC	0.000000			90.00
90.01	04951 CHEMO/PAIN	0.000000			90.01
90.02	09002 SENIOR CARE	0.000000			90.02
90.03	09003 SLEEP LAB	0.000000			90.03
90.04	09001 ORTHOPEDICS	0.000000			90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	0.000000			90.05
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/24/2022 9:58 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	588,197	18,634,145	0.031566	1,415,123	44,670
53.00	05300	ANESTHESIOLOGY	15,954	2,664,398	0.005988	162,558	973
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,301	35,026,514	0.010058	626,642	6,303
60.00	06000	LABORATORY	172,815	22,712,932	0.007609	917,536	6,982
65.00	06500	RESPIRATORY THERAPY	31,945	1,089,387	0.029324	154,344	4,526
66.00	06600	PHYSICAL THERAPY	917,993	10,481,072	0.087586	227,517	19,927
69.00	06900	ELECTROCARDIOLOGY	23,101	2,219,102	0.010410	39,891	415
70.00	07000	ELECTROENCEPHALOGRAPHY	6	8,841	0.000679	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,409	6,244,114	0.010796	429,558	4,638
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,667	2,720,543	0.007229	491,043	3,550
73.00	07300	DRUGS CHARGED TO PATIENTS	102,476	13,387,209	0.007655	1,051,321	8,048
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	112,078	8,624,727	0.012995	0	0
88.01	08801	RURAL HEALTH CLINIC II	54,664	813,843	0.067168	0	0
88.02	08802	RURAL HEALTH CLINIC III	7,489	485,021	0.015441	0	0
88.03	08803	RURAL HEALTH CLINIC IV	384,533	4,001,303	0.096102	0	0
88.04	08804	RURAL HEALTH CLINIC V	56,194	1,124,181	0.049987	0	0
90.00	09000	CLINIC	31,870	233,388	0.136554	0	0
90.01	04951	CHEMO/PAIN	88,568	1,673,157	0.052935	293	16
90.02	09002	SENIOR CARE	9,695	497,341	0.019494	0	0
90.03	09003	SLEEP LAB	6,290	131,690	0.047764	0	0
90.04	09001	ORTHOPEDICS	89,843	893,779	0.100520	0	0
90.05	09004	BEHAVIORAL HEALTH CLINIC	18,705	161,285	0.115975	0	0
91.00	09100	EMERGENCY	266,394	8,141,948	0.032719	337	11
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	257,111	1,321,013	0.194632	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	3,675,298	143,290,933		5,516,163	100,059

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0 88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0 88.04
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0 90.01
90.02	09002	SENIOR CARE	0	0	0	0	0 90.02
90.03	09003	SLEEP LAB	0	0	0	0	0 90.03
90.04	09001	ORTHOPEDICS	0	0	0	0	0 90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		Title XVIII		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	18,634,145	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,664,398	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,026,514	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	22,712,932	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,089,387	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,481,072	0.000000 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,219,102	0.000000 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,841	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,244,114	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,720,543	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,387,209	0.000000 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,624,727	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	813,843	0.000000 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	485,021	0.000000 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	4,001,303	0.000000 88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,124,181	0.000000 88.04
90.00	09000	CLINIC	0	0	0	233,388	0.000000 90.00
90.01	04951	CHEMO/PAIN	0	0	0	1,673,157	0.000000 90.01
90.02	09002	SENIOR CARE	0	0	0	497,341	0.000000 90.02
90.03	09003	SLEEP LAB	0	0	0	131,690	0.000000 90.03
90.04	09001	ORTHOPEDICS	0	0	0	893,779	0.000000 90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	161,285	0.000000 90.05
91.00	09100	EMERGENCY	0	0	0	8,141,948	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,321,013	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	143,290,933	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 9:58 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	1,415,123	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	162,558	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	626,642	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	917,536	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	154,344	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	227,517	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	39,891	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	429,558	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	491,043	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,051,321	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0.000000	293	0	0	0	90.01
90.02	09002	SENIOR CARE	0.000000	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0.000000	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	337	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,516,163	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 9:58 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	0.217541	0	3,616,033	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.333592	0	527,592	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139909	0	9,460,868	0	0	54.00
60.00	06000	LABORATORY	0.169894	0	5,963,804	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.241064	0	203,909	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.450469	0	2,693,839	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.094581	0	656,213	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.008257	0	2,659	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.894435	0	1,422,908	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.760253	0	451,840	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414734	0	3,380,816	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
90.00	09000	CLINIC	2.908290	0	99,037	0	0	90.00
90.01	04951	CHEMO/PAIN	1.263611	0	428,491	0	0	90.01
90.02	09002	SENIOR CARE	1.594658	0	463,829	0	0	90.02
90.03	09003	SLEEP LAB	0.883507	0	45,549	0	0	90.03
90.04	09001	ORTHOPEDICS	1.506727	0	231,615	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	1.443544	0	8,889	0	0	90.05
91.00	09100	EMERGENCY	0.639165	0	2,099,717	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.109718	0	419,414	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.035506		0			95.00
200.00		Subtotal (see instructions)		0	32,177,022	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	32,177,022	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 9:58 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	786,635	0	50.00
53.00	05300	ANESTHESIOLOGY	176,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,661	0	54.00
60.00	06000	LABORATORY	1,013,215	0	60.00
65.00	06500	RESPIRATORY THERAPY	253,064	0	65.00
66.00	06600	PHYSICAL THERAPY	1,213,491	0	66.00
69.00	06900	ELECTROCARDIOLOGY	62,065	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,272,699	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	343,513	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,402,139	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
90.00	09000	CLINIC	288,028	0	90.00
90.01	04951	CHEMO/PAIN	541,446	0	90.01
90.02	09002	SENIOR CARE	739,649	0	90.02
90.03	09003	SLEEP LAB	40,243	0	90.03
90.04	09001	ORTHOPEDICS	348,981	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	12,832	0	90.05
91.00	09100	EMERGENCY	1,342,066	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	884,845	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	12,044,594	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	12,044,594	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 9:58 am

			Title XIX		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	0.217541	0	0	258,327	0	50.00
53.00	05300	ANESTHESIOLOGY	0.333592	0	0	39,218	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139909	0	0	652,610	0	54.00
60.00	06000	LABORATORY	0.169894	0	0	380,337	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.241064	0	0	10,012	0	65.00
66.00	06600	PHYSICAL THERAPY	0.450469	0	0	76,131	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.094581	0	0	52,515	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.008257	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.894435	0	0	119,828	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.760253	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414734	0	0	126,840	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
90.00	09000	CLINIC	2.908290	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.263611	0	0	36,482	0	90.01
90.02	09002	SENIOR CARE	1.594658	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.883507	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1.506727	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	1.443544	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.639165	0	0	233,576	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.109718	0	0	24,926	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.035506	0	0			95.00
200.00		Subtotal (see instructions)		0	0	2,010,802	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,010,802	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/24/2022 9:58 am

			Title XIX		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	0	56,197		50.00
53.00	05300	ANESTHESIOLOGY	0	13,083		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,306		54.00
60.00	06000	LABORATORY	0	64,617		60.00
65.00	06500	RESPIRATORY THERAPY	0	12,426		65.00
66.00	06600	PHYSICAL THERAPY	0	34,295		66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,967		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	107,178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,605		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	46,099		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
90.04	09001	ORTHOPEDICS	0	0		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	149,294		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	52,587		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	684,654		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	684,654		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 9:58 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)	5,116			1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,415			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)	2,061			4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	753			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	224			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)	1,223			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)	529			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	149.97			19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	149.97			20.00
21.00	Total general inpatient routine service cost (see instructions)	8,612,646			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)	33,593			24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0			25.00
26.00	Total swing-bed cost (see instructions)	1,583,500			26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,029,146			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)	7,029,146			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)	2,058.31			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,517,313			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)	2,517,313			41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1320

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,097,578	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,614,891	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,088,846	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,088,846	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)					1,354	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,058.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,786,965	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1320

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

Worksheet D-1

Date/Time Prepared:
5/24/2022 9:58 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	794,560	8,612,646	0.092255	2,786,965	257,111
91.00	Nursing Program cost	0	8,612,646	0.000000	2,786,965	0
92.00	Allied health cost	0	8,612,646	0.000000	2,786,965	0
93.00	All other Medical Education	0	8,612,646	0.000000	2,786,965	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 9:58 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		1,194,781		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.217541	1,415,123	307,847	50.00
53.00	05300 ANESTHESIOLOGY	0.333592	162,558	54,228	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139909	626,642	87,673	54.00
60.00	06000 LABORATORY	0.169894	917,536	155,884	60.00
65.00	06500 RESPIRATORY THERAPY	1.241064	154,344	191,551	65.00
66.00	06600 PHYSICAL THERAPY	0.450469	227,517	102,489	66.00
69.00	06900 ELECTROCARDIOLOGY	0.094581	39,891	3,773	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.008257	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.894435	429,558	384,212	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.760253	491,043	373,317	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414734	1,051,321	436,019	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000 CLINIC	2.908290	0	0	90.00
90.01	04951 CHEMO/PAIN	1.263611	293	370	90.01
90.02	09002 SENIOR CARE	1.594658	0	0	90.02
90.03	09003 SLEEP LAB	0.883507	0	0	90.03
90.04	09001 ORTHOPEDICS	1.506727	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	1.443544	0	0	90.05
91.00	09100 EMERGENCY	0.639165	337	215	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.109718	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,516,163	2,097,578	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)		5,516,163		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320 Component CCN: 14-Z320	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 9:58 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.217541	8,816	1,918	50.00
53.00	05300 ANESTHESIOLOGY	0.333592	26	9	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139909	58,921	8,244	54.00
60.00	06000 LABORATORY	0.169894	128,250	21,789	60.00
65.00	06500 RESPIRATORY THERAPY	1.241064	31,495	39,087	65.00
66.00	06600 PHYSICAL THERAPY	0.450469	322,304	145,188	66.00
69.00	06900 ELECTROCARDIOLOGY	0.094581	2,352	222	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.008257	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.894435	56,286	50,344	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.760253	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414734	193,863	80,402	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000 CLINIC	2.908290	0	0	90.00
90.01	04951 CHEMO/PAIN	1.263611	0	0	90.01
90.02	09002 SENIOR CARE	1.594658	0	0	90.02
90.03	09003 SLEEP LAB	0.883507	0	0	90.03
90.04	09001 ORTHOPEDICS	1.506727	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	1.443544	0	0	90.05
91.00	09100 EMERGENCY	0.639165	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.109718	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		802,313	347,203	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)		802,313		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 9:58 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		25,608		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.217541	7,116	1,548	50.00
53.00	05300 ANESTHESIOLOGY	0.333592	1,511	504	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139909	7,320	1,024	54.00
60.00	06000 LABORATORY	0.169894	25,517	4,335	60.00
65.00	06500 RESPIRATORY THERAPY	1.241064	7,321	9,086	65.00
66.00	06600 PHYSICAL THERAPY	0.450469	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.094581	5,863	555	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.008257	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.894435	8,937	7,994	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.760253	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414734	28,507	11,823	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.499252	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.950639	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.781067	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	1.036352	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.546619	0	0	88.04
90.00	09000 CLINIC	2.908290	0	0	90.00
90.01	04951 CHEMO/PAIN	1.263611	0	0	90.01
90.02	09002 SENIOR CARE	1.594658	0	0	90.02
90.03	09003 SLEEP LAB	0.883507	0	0	90.03
90.04	09001 ORTHOPEDICS	1.506727	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	1.443544	0	0	90.05
91.00	09100 EMERGENCY	0.639165	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.109718	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		92,092	36,869	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)		92,092		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 9:58 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			12,044,594 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)			12,044,594 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)			12,165,040 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)			69,190 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,202,454 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)			6,893,396 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)			6,893,396 30.00
31.00	Primary payer payments			1,398 31.00
32.00	Subtotal (line 30 minus line 31)			6,891,998 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)			245,013 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			159,258 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,433 36.00
37.00	Subtotal (see instructions)			7,051,256 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)			7,051,256 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			7,051,345 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)			-89 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			85,755 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: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/24/2022 9:58 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		3,267,699		6,737,641	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	08/11/2021	239,647	08/11/2021	313,704	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)		239,647		313,704	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)		3,507,346		7,051,345	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		763,218		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		89	6.02
7.00	Total Medicare program liability (see instructions)		4,270,564		7,051,256	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: 14-1320

Period:

Worksheet E-1

Component CCN: 14-Z320

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/24/2022 9:58 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		1,100,885		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	08/11/2021	104,832		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)		104,832		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)		1,205,717		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		224,658		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,430,375		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: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part II
Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII	Hospital	Cost
				1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2	
		Component CCN: 14-Z320		Date/Time Prepared: 5/24/2022 9:58 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,099,734	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)		350,675	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		529	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)		1,450,409	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,450,409	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)		1,450,409	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		20,034	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,430,375	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)		1,430,375	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		1,205,717	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)		224,658	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: 14-1320	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/24/2022 9:58 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		4,614,891	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)		4,614,891	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,661,040	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)		4,661,040	19.00
20.00	Deductibles (exclude professional component)		422,958	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		4,238,082	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		4,238,082	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		49,972	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		32,482	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,270,564	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)		4,270,564	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		3,507,346	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)		763,218	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		17,490	34.00

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

Provider CCN: 14-1320

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

Worksheet G

Date/Time Prepared:
5/24/2022 9:58 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	3,571,451	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	32,934,707	0	0	0	4.00
5.00	Other receivable	4,612,484	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,372,064	0	0	0	6.00
7.00	Inventory	2,520,522	0	0	0	7.00
8.00	Prepaid expenses	829,217	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)	25,096,317	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,626,832	0	0	0	12.00
13.00	Land improvements	3,469,016	0	0	0	13.00
14.00	Accumulated depreciation	-2,095,180	0	0	0	14.00
15.00	Buildings	52,655,131	0	0	0	15.00
16.00	Accumulated depreciation	-22,331,068	0	0	0	16.00
17.00	Leasehold improvements	11,366,018	0	0	0	17.00
18.00	Accumulated depreciation	-85,241	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	24,339,076	0	0	0	23.00
24.00	Accumulated depreciation	-18,422,701	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)	50,521,883	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,618,200	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,156,780	0	0	0	37.00
38.00	Salaries, wages, and fees payable	43,487	0	0	0	38.00
39.00	Payroll taxes payable	5,120,573	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,607,265	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	0	0	0	0	43.00
44.00	Other current liabilities	2,128,254	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,056,359	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,056,359	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	52,561,841	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)	52,561,841	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,618,200	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1320

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

Worksheet G-1

Date/Time Prepared:
5/24/2022 9:58 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		47,210,935		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,350,906				2.00
3.00	Total (sum of line 1 and line 2)		52,561,841		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)		52,561,841		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)		52,561,841		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: 14-1320

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2022 9:58 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,174,110		7,174,110	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,174,110		7,174,110	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)	7,174,110		7,174,110	17.00
18.00	Ancillary services	10,634,420	145,150,126	155,784,546	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	353	8,624,374	8,624,727	20.00
20.01	RURAL HEALTH CLINIC II	0	813,843	813,843	20.01
20.02	RURAL HEALTH CLINIC III	0	485,021	485,021	20.02
20.03	RURAL HEALTH CLINIC IV	0	4,001,303	4,001,303	20.03
20.04	RURAL HEALTH CLINIC V	0	1,124,181	1,124,181	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,808,883	160,198,848	178,007,731	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		85,277,623		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)		85,277,623		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1320

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

Worksheet G-3

Date/Time Prepared:
5/24/2022 9:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	178,007,731	1.00
2.00	Less contractual allowances and discounts on patients' accounts	93,378,186	2.00
3.00	Net patient revenues (line 1 minus line 2)	84,629,545	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	85,277,623	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-648,078	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,491,563	6.00
7.00	Income from investments	49,093	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	11,867	10.00
11.00	Rebates and refunds of expenses	12,601	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	159,120	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	2,353	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	5,860	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	213,886	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,239,912	24.00
24.01	PHARMACY	1,804,594	24.01
24.02	OTHER	0	24.02
24.03	PHYSICIAN LICENSE REVENUE	42,710	24.03
24.50	COVID-19 PHE Funding	965,425	24.50
25.00	Total other income (sum of lines 6-24)	5,998,984	25.00
26.00	Total (line 5 plus line 25)	5,350,906	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)	5,350,906	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

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

Date/Time Prepared:

5/24/2022 9:58 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,430,837	0	3,430,837	-45,791	3,385,046 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	1,050,354	0	1,050,354	-1,665	1,048,689 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	1,515,146	0	1,515,146	0	1,515,146 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	671,626	0	671,626	0	671,626 9.00
10.00	Subtotal (sum of lines 1 through 9)	6,667,963	0	6,667,963	-47,456	6,620,507 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	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	53,629	53,629	0	53,629 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	223,479	223,479	0	223,479 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	277,108	277,108	0	277,108 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,667,963	277,108	6,945,071	-47,456	6,897,615 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	47,456	47,456 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	47,456	47,456 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	299,941	299,941	0	299,941 29.00
30.00	Administrative Costs	1,221,292	3,001,879	4,223,171	0	4,223,171 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,221,292	3,301,820	4,523,112	0	4,523,112 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,889,255	3,578,928	11,468,183	0	11,468,183 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	3,385,046		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,048,689		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,515,146		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	671,626		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	6,620,507		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	53,629		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	223,479		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	277,108		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	6,897,615		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	47,456		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	47,456		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	299,941		29.00
30.00	Administrative Costs	-160,574	4,062,597		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-160,574	4,362,538		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-160,574	11,307,609		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

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

Date/Time Prepared:

5/24/2022 9:58 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	241,508	0	241,508	-1,902	239,606
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	149,004	0	149,004	0	149,004
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	390,512	0	390,512	-1,902	388,610
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	17,690	17,690	0	17,690
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	16,601	16,601	0	16,601
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	34,291	34,291	0	34,291
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	390,512	34,291	424,803	-1,902	422,901
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	1,902	1,902
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,902	1,902
FACILITY OVERHEAD						
29.00	Facility Costs	0	8,105	8,105	0	8,105
30.00	Administrative Costs	52,962	147,705	200,667	0	200,667
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,962	155,810	208,772	0	208,772
32.00	Total facility costs (sum of lines 22, 28 and 31)	443,474	190,101	633,575	0	633,575

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	239,606		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	149,004		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	388,610		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	17,690		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	16,601		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	34,291		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	422,901		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	1,902		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,902		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	8,105		29.00
30.00	Administrative Costs	-4,972	195,695		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,972	203,800		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,972	628,603		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

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

Date/Time Prepared:

5/24/2022 9:58 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	414,725	0	414,725	0	414,725
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	96,621	0	96,621	-663	95,958
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	51,578	0	51,578	0	51,578
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	562,924	0	562,924	-663	562,261
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	833	833	0	833
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	7,481	7,481	0	7,481
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	8,314	8,314	0	8,314
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	562,924	8,314	571,238	-663	570,575
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	663	663
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	663	663
FACILITY OVERHEAD						
29.00	Facility Costs	0	7,966	7,966	0	7,966
30.00	Administrative Costs	40,599	148,891	189,490	0	189,490
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,599	156,857	197,456	0	197,456
32.00	Total facility costs (sum of lines 22, 28 and 31)	603,523	165,171	768,694	0	768,694

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	414,725	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	95,958	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	51,578	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	562,261	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	833	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	7,481	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,314	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	570,575	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	663	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	663	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,966	29.00
30.00	Administrative Costs	-13,270	176,220	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-13,270	184,186	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,270	755,424	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

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

Date/Time Prepared:

5/24/2022 9:58 am

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	398,075	0	398,075	0	398,075	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,021,365	0	1,021,365	-459	1,020,906	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	219,507	0	219,507	0	219,507	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	315,623	0	315,623	0	315,623	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,954,570	0	1,954,570	-459	1,954,111	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	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	72,787	72,787	0	72,787	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	18,461	18,461	0	18,461	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	91,248	91,248	0	91,248	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,954,570	91,248	2,045,818	-459	2,045,359	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	459	459	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	459	459	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	20,110	20,110	0	20,110	29.00
30.00	Administrative Costs	324,357	888,152	1,212,509	0	1,212,509	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	324,357	908,262	1,232,619	0	1,232,619	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,278,927	999,510	3,278,437	0	3,278,437	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	398,075	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	1,020,906	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	219,507	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	315,623	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,954,111	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	72,787	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	18,461	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	91,248	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,045,359	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	459	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	459	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	20,110	29.00
30.00	Administrative Costs	-763	1,211,746	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-763	1,231,856	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-763	3,277,674	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

						RHC V		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	2,769	0	2,769	0	2,769	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	237,606	0	237,606	0	237,606	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	10,975	0	10,975	0	10,975	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	70,813	0	70,813	0	70,813	9.00		
10.00	Subtotal (sum of lines 1 through 9)	322,163	0	322,163	0	322,163	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	1,726	1,726	0	1,726	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	0	0	0	0	19.00		
20.00	Allowable GME Costs	0	0	0	0	0	20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	1,726	1,726	0	1,726	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	322,163	1,726	323,889	0	323,889	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs	0	0	0	0	0	27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	22,128	22,128	0	22,128	29.00		
30.00	Administrative Costs	47,663	97,359	145,022	0	145,022	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,663	119,487	167,150	0	167,150	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	369,826	121,213	491,039	0	491,039	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		RHC V		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,769	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	237,606	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	10,975	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	70,813	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	322,163	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	1,726	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,726	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	323,889	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	22,128	29.00
30.00	Administrative Costs	-4,539	140,483	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,539	162,611	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,539	486,500	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3987

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

Date/Time Prepared:

5/24/2022 9:58 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	4.99	28,091	4,200	20,958		1.00
2.00	Physician Assistant	0.00		2,100	0		2.00
3.00	Nurse Practitioner	4.86	14,486	2,100	10,206		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.85	42,577		31,164	42,577	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.85	42,577			42,577	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					6,897,615	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					47,456	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					6,945,071	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993167	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					4,362,538	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,623,033	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,985,571	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,985,571	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,944,672	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					12,842,287	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3989

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

Date/Time Prepared:

5/24/2022 9:58 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.41	4,050	2,100	2,961		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	4,050		2,961	4,050	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.41	4,050			4,050	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					422,901	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,902	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					424,803	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995523	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					203,800	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					145,068	15.00
16.00	Total overhead (sum of lines 14 and 15)					348,868	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					348,868	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					347,306	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					770,207	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8596

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

Date/Time Prepared:

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				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.47	1,214	4,200	1,974		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.63	1,302	2,100	1,323		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.10	2,516		3,297	3,297	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.10	2,516			3,297	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					570,575	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					663	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					571,238	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998839	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					184,186	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					108,431	15.00
16.00	Total overhead (sum of lines 14 and 15)					292,617	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					292,617	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					292,277	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					862,852	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8607

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

Date/Time Prepared:

5/24/2022 9:58 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.42	1,201	4,200	1,764		1.00
2.00	Physician Assistant	0.08	202	2,100	168		2.00
3.00	Nurse Practitioner	3.75	17,785	2,100	7,875		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.25	19,188		9,807	19,188	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.25	19,188			19,188	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,045,359	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					459	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,045,818	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999776	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,231,856	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					869,085	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,100,941	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,100,941	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,100,470	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,145,829	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8606

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

Date/Time Prepared:

5/24/2022 9:58 am

				RHC V		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.10	239	4,200	420		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.67	5,032	2,100	3,507		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.77	5,271		3,927	5,271	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.77	5,271			5,271	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					323,889	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					323,889	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					162,611	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					127,999	15.00
16.00	Total overhead (sum of lines 14 and 15)					290,610	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					290,610	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					290,610	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					614,499	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 9:58 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)			12,842,287	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			330,831	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			12,511,456	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			42,577	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)			42,577	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			293.85	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	299.08	8.00
9.00	Rate for Program covered visits (see instructions)		293.85	293.85	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		2,907	8,531	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		854,222	2,506,834	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	3,361,056	16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,024,709	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			81,762	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			135,726	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.)			2,419,334	16.04
16.05	Total program cost (see instructions)		0	2,555,060	16.05
17.00	Primary payer amounts			199	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			201,163	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			348,357	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			2,554,861	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			100,475	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			2,655,336	22.00
23.00	Allowable bad debts (see instructions)			49,190	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			31,974	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,079	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)			2,687,310	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			2,564,785	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)			122,525	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 9:58 am
		Title XVIII	RHC II	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		770,207	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		39,240	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		730,967	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,050	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)		4,050	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		180.49	7.00
		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	220.22	8.00
9.00	Rate for Program covered visits (see instructions)	180.49	180.49	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	131	441	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	23,644	79,596	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	103,240	16.00
16.01	Total program charges (see instructions)(from contractor's records)		125,759	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,724	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,341	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.)		66,570	16.04
16.05	Total program cost (see instructions)	0	72,911	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,686	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,870	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		72,911	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,303	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		84,214	22.00
23.00	Allowable bad debts (see instructions)		1,093	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		710	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		294	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)		84,924	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		84,958	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)		-34	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8596	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 9:58 am	
		Title XVIII	RHC III	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			862,852	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			16,862	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			845,990	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,297	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,297	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			256.59	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	345.85	8.00
9.00	Rate for Program covered visits (see instructions)		256.59	256.59	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		177	505	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		45,416	129,578	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	174,994	16.00
16.01	Total program charges (see instructions)(from contractor's records)			130,514	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			5,269	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			7,065	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.)			120,675	16.04
16.05	Total program cost (see instructions)		0	127,740	16.05
17.00	Primary payer amounts			171	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,085	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			21,632	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			127,569	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,222	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			134,791	22.00
23.00	Allowable bad debts (see instructions)			507	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			330	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			58	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)			135,121	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			170,610	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)			-35,489	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8607	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 9:58 am	
		Title XVIII	RHC IV	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)			4,145,829	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			2,969	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,142,860	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,188	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)			19,188	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			215.91	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			87.52	8.00
9.00	Rate for Program covered visits (see instructions)			215.91	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	432		1,800	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	93,273		388,638	11.00
12.00	Program covered visits for mental health services (from contractor records)	0		0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0		0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0		0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0		481,911	16.00
16.01	Total program charges (see instructions)(from contractor's records)			600,847	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			65,744	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			52,730	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.)			316,378	16.04
16.05	Total program cost (see instructions)	0		369,108	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			33,708	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			100,279	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			369,108	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			619	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			369,727	22.00
23.00	Allowable bad debts (see instructions)			4,010	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,607	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,386	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)			372,334	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			548,900	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)			-176,566	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/24/2022 9:58 am		
		Title XVIII	RHC V	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)			614,499	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,131	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			613,368	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,271	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)			5,271	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			116.37	7.00	
			Calculation of Limit (1)			
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			87.52	123.14	8.00
9.00	Rate for Program covered visits (see instructions)			116.37	116.37	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			87	409	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			10,124	47,595	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	57,719	16.00
16.01	Total program charges (see instructions)(from contractor's records)				82,467	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				29,472	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				20,628	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.)				25,051	16.04
16.05	Total program cost (see instructions)			0	45,679	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				5,777	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				9,444	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				45,679	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				323	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				46,002	22.00
23.00	Allowable bad debts (see instructions)				836	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				543	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)				46,545	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				47,712	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)				-1,167	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: 14-1320

Period:

Worksheet M-4

Component CCN: 14-3987

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	6,620,507	6,620,507	6,620,507	6,620,507	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003563	0.008655	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	23,589	57,300	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	67,010	29,792	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	90,599	87,092	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	6,897,615	6,897,615	6,897,615	6,897,615	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,944,672	5,944,672	5,944,672	5,944,672	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013135	0.012626	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	78,083	75,057	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	168,682	162,149	0	0	10.00
11.00	Total number of injections/infusions (from your records)	438	1,064	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	385.12	152.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	103	399	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	39,667	60,808	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		330,831			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)		100,475			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320

Period:

Worksheet M-4

Component CCN: 14-3989

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	388,610	388,610	388,610	388,610	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003580	0.011933	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,391	4,637	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,638	5,880	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,029	10,517	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	422,901	422,901	422,901	422,901	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	347,306	347,306	347,306	347,306	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026079	0.024869	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,057	8,637	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,086	19,154	0	0	10.00
11.00	Total number of injections/infusions (from your records)	63	210	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	318.83	91.21	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	68	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,101	6,202	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		39,240			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)		11,303			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320

Period:

Worksheet M-4

Component CCN: 14-8596

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	562,261	562,261	562,261	562,261	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000510	0.010344	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	287	5,816	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,071	3,976	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,358	9,792	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	570,575	570,575	570,575	570,575	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	292,277	292,277	292,277	292,277	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002380	0.017162	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	696	5,016	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,054	14,808	0	0	10.00
11.00	Total number of injections/infusions (from your records)	7	142	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	293.43	104.28	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	58	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,174	6,048	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		16,862			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)		7,222			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320

Period:

Worksheet M-4

Component CCN: 14-8607

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII		RHC IV	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)	1,954,111	1,954,111	1,954,111	1,954,111	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000406	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	793	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	672	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	1,465	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,045,359	2,045,359	2,045,359	2,045,359	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,100,470	2,100,470	2,100,470	2,100,470	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000716	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	1,504	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	2,969	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	24	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	123.71	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	5	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	619	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,969			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)		619			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320

Period:

Worksheet M-4

Component CCN: 14-8606

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 9:58 am

		Title XVIII		RHC V	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)	322,163	322,163	322,163	322,163	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000634	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	204	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	392	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	596	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	323,889	323,889	323,889	323,889	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	290,610	290,610	290,610	290,610	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001840	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	535	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	1,131	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	14	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	80.79	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	4	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	323	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		1,131			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)		323			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 9:58 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		2,530,679	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) Program to Provider			3.00	
3.01		08/11/2021	34,106	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)		34,106	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,564,785	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) Program to Provider			5.00	
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		122,525	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,687,310	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 9:58 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			84,958	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)			84,958	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			34	6.02
7.00	Total Medicare program liability (see instructions)			84,924	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-8596	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 9:58 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			131,077	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			08/11/2021	39,533	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)			39,533	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			170,610	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			35,489	6.02
7.00	Total Medicare program liability (see instructions)			135,121	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-8607	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 9:58 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			501,468	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			08/11/2021	47,432	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)			47,432	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			548,900	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			176,566	6.02
7.00	Total Medicare program liability (see instructions)			372,334	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/24/2022 9:58 am	
		RHC V	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		47,712	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)		47,712	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		1,167	6.02	
7.00	Total Medicare program liability (see instructions)		46,545	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00