

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: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 1:44 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021	Time: 1:44 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANKLIN HOSPITAL (14-1321) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JAMES JOHNSON

Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	125,039	-55,495	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	89,928	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		301,273		0	10.00
10.01	RURAL HEALTH CLINIC II	0		6,334		0	10.01
200.00	Total	0	214,967	252,112	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: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 1:44 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 201 BAILEY LANE			PO Box:				1.00		
2.00	City: BENTON			State: IL		Zip Code: 62812		County: FRANKLIN		
		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		FRANKLIN HOSPITAL	141321	99914	1	08/01/2002	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		FRANKLIN HOSPITAL SWING BED	14Z321	99914		08/01/2002	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		FRANKLIN RHC	143469	99914		07/06/2005	N	O	N
15.01	Hospital-Based Health Clinic - RHC I		WEST FRANKFORT RHC	148510	99914		04/23/2010	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						9			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.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 1:44 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 1:44 pm	
			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 1.00	XIX 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)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 1:44 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	167,651	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 1:44 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							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
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 1:44 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	11/17/2021	Y	11/17/2021
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		N	
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: 14-1321

Period:
From 07/01/2020
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Date/Time Prepared:
11/29/2021 1:44 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1321

Period:
From 07/01/2020
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	7,752.00	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	7,752.00	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	7,752.00	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
26.25 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: 14-1321

Period:
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To 06/30/2021Worksheet S-3
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Date/Time Prepared:
11/29/2021 1:44 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	243	20	323			1.00
2.00	HMO and other (see instructions)	19	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	163	0	194			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	12			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	406	20	529			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)	406	20	529	0.00	128.18	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	5,717	457	16,162	0.00	20.90	26.00
26.01	RURAL HEALTH CLINIC II	405	118	2,031	0.00	2.03	26.01
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	151.11	27.00
28.00	Observation Bed Days		0	154			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: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	82	3	114	1.00
2.00 HMO and other (see instructions)			8	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	82	3	114	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
26.25 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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1321
 Component CCN: 14-3469

 Period:
 From 07/01/2020
 To 06/30/2021

 Worksheet S-8
 Date/Time Prepared:
 11/29/2021 1:44 pm

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	201 BAILEY LANE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BENTON IL		62812 2.00	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC 12:00 18:00 09:00 20:00 09:00 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
		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)			Total Visits 5.00 15.00	
		County		4.00	
2.00	City, State, ZIP Code, County			FRANKLIN 2.00	
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		Friday		Saturday	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC 20:00 09:00 20:00 09:00 20:00 11.00			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321

Period:

Worksheet S-8

Component CCN: 14-3469

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	09:00	20:00	09:00	19:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1321
 Component CCN: 14-8510

 Period:
 From 07/01/2020
 To 06/30/2021

 Worksheet S-8
 Date/Time Prepared:
 11/29/2021 1:44 pm

		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street			309 WEST ST. LOUIS STREET	1.00
	City			State	ZIP Code
	1.00			2.00	3.00
2.00	City, State, ZIP Code, County			WEST FRANKFORT	IL 62896
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
				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
	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			09:00 17:00	09:00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			N	
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
	Provider name			CCN number	
	1.00			2.00	
14.00	RHC/FQHC name, CCN number				
	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)				
	County				
	4.00				
2.00	City, State, ZIP Code, County			FRANKLIN	
	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 09:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321

Period:

Worksheet S-8

Component CCN: 14-8510

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 1:44 pm
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.491171	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,758,999	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,889,218	5.00
6.00	Medicaid charges		9,732,506	6.00
7.00	Medicaid cost (line 1 times line 6)		4,780,325	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,132,108	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		62,463	9.00
10.00	Stand-alone CHIP charges		73,062	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		35,886	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,132,108	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)	130,747	61,528	192,275
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	64,219	61,528	125,747
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	64,219	61,528	125,747
		1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,871,465	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		526,915	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		810,637	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,060,828	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		804,770	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		930,517	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,062,625	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		216,694	216,694	134,677	351,371	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		735,396	735,396	97,339	832,735	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	115,449	1,912,637	2,028,086	0	2,028,086	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,566,965	1,573,410	3,140,375	35,359	3,175,734	5.00
6.00	00600	MAINTENANCE & REPAIRS	263,228	205,670	468,898	0	468,898	6.00
7.00	00700	OPERATION OF PLANT	0	367,966	367,966	0	367,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,113	71,113	0	71,113	8.00
9.00	00900	HOUSEKEEPING	235,000	69,738	304,738	0	304,738	9.00
10.00	01000	DIETARY	151,668	149,050	300,718	-265,530	35,188	10.00
11.00	01100	CAFETERIA	0	0	0	265,530	265,530	11.00
13.00	01300	NURSING ADMINISTRATION	500,556	66,529	567,085	0	567,085	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	91,402	13,019	104,421	0	104,421	14.00
15.00	01500	PHARMACY	230,520	1,247,212	1,477,732	-864,411	613,321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	234,104	87,232	321,336	0	321,336	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,038,310	502,335	1,540,645	866	1,541,511	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	171,865	175,483	347,348	0	347,348	50.00
53.00	05300	ANESTHESIOLOGY	0	53,134	53,134	0	53,134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,303	162,941	626,244	-106,545	519,699	54.00
57.00	05700	CT SCAN	0	96,871	96,871	106,545	203,416	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	52,702	52,702	0	52,702	58.00
60.00	06000	LABORATORY	399,436	1,282,611	1,682,047	-1,953	1,680,094	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	15,104	15,104	1,953	17,057	63.00
65.00	06500	RESPIRATORY THERAPY	226,695	73,053	299,748	0	299,748	65.00
66.00	06600	PHYSICAL THERAPY	0	236,466	236,466	0	236,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63,228	63,228	0	63,228	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,351	49,351	0	49,351	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,603	24,603	0	24,603	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	864,411	864,411	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	116,966	159,042	276,008	0	276,008	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,082,437	822,887	2,905,324	-866	2,904,458	88.00
88.01	08801	RURAL HEALTH CLINIC II	188,972	90,764	279,736	0	279,736	88.01
91.00	09100	EMERGENCY	590,091	1,958,478	2,548,569	0	2,548,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		267,375	267,375	-267,375	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,666,967	12,802,094	21,469,061	0	21,469,061	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	406,909	58,939	465,848	0	465,848	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,073,876	12,861,033	21,934,909	0	21,934,909	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6	351,365	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4	832,731	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,162	2,023,924	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-135,328	3,040,406	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	468,898	6.00
7.00	00700	OPERATION OF PLANT	-85,609	282,357	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,113	8.00
9.00	00900	HOUSEKEEPING	0	304,738	9.00
10.00	01000	DIETARY	0	35,188	10.00
11.00	01100	CAFETERIA	-64,977	200,553	11.00
13.00	01300	NURSING ADMINISTRATION	0	567,085	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	104,421	14.00
15.00	01500	PHARMACY	-376,166	237,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,911	316,425	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-445,872	1,095,639	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,050	346,298	50.00
53.00	05300	ANESTHESIOLOGY	-47,677	5,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	519,699	54.00
57.00	05700	CT SCAN	0	203,416	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	52,702	58.00
60.00	06000	LABORATORY	0	1,680,094	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	17,057	63.00
65.00	06500	RESPIRATORY THERAPY	-12,199	287,549	65.00
66.00	06600	PHYSICAL THERAPY	0	236,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63,228	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,351	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,603	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,396	863,015	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	276,008	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,904,458	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	279,736	88.01
91.00	09100	EMERGENCY	-422,158	2,126,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,601,515	19,867,546	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	465,848	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,601,515	20,333,394	200.00

RECLASSIFICATIONS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 1:44 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CAFETERIA COST					1.00
	CAFETERIA	11.00	133,921	131,609		
	0		133,921	131,609		
B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97,406	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	73,433	2.00	
3.00	ADMINISTRATIVE & GENERAL	5.00	0	96,536	3.00	
	0		0	267,375		
C - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	61,177	1.00	
	0		0	61,177		
H - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	864,411	1.00	
	0		0	864,411		
J - CT SCAN COSTS						
1.00	CT_SCAN	57.00	99,227	7,318	1.00	
	0		99,227	7,318		
K - BLOOD						
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	1,820	133	1.00	
	0		1,820	133		
L - RHC HOSPITALIST TIME						
1.00	ADULTS & PEDIATRICS	30.00	815	51	1.00	
	TOTALS		815	51		
500.00	Grand Total: Increases		235,783	1,332,074	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/29/2021 1:44 pm

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
1.00	A - CAFETERIA COST							
	DIETARY	10.00	133,921	131,609	0			1.00
	0		133,921	131,609				
	B - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	267,375	11			1.00
2.00		0.00	0	0	11			2.00
3.00		0.00	0	0	0			3.00
	0		0	267,375				
	C - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,177	0			1.00
	0		0	61,177				
	H - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	864,411	0			1.00
	0		0	864,411				
	J - CT SCAN COSTS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	99,227	7,318	0			1.00
	0		99,227	7,318				
	K - BLOOD							
1.00	LABORATORY	60.00	1,820	133	0			1.00
	0		1,820	133				
	L - RHC HOSPITALIST TIME							
1.00	RURAL HEALTH CLINIC	88.00	815	51	0			1.00
	TOTALS		815	51				
500.00	Grand Total: Decreases		235,783	1,332,074				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,401	0	0	0	0	1.00	
2.00	Land Improvements	225,124	196,307	0	196,307	0	2.00	
3.00	Buildings and Fixtures	5,410,832	0	0	0	0	3.00	
4.00	Building Improvements	5,981,581	43,711	0	43,711	0	4.00	
5.00	Fixed Equipment	3,247,041	85,837	0	85,837	0	5.00	
6.00	Movable Equipment	8,378,872	0	0	0	0	6.00	
7.00	HIT designated Assets	0	1,376,369	0	1,376,369	0	7.00	
8.00	Subtotal (sum of lines 1-7)	23,261,851	1,702,224	0	1,702,224	0	8.00	
9.00	Reconciling Items	-110,517	-1,842,854	0	-1,842,854	-1,710,150	9.00	
10.00	Total (line 8 minus line 9)	23,372,368	3,545,078	0	3,545,078	1,710,150	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,401	0				1.00	
2.00	Land Improvements	421,431	0				2.00	
3.00	Buildings and Fixtures	5,410,832	0				3.00	
4.00	Building Improvements	6,025,292	0				4.00	
5.00	Fixed Equipment	3,332,878	0				5.00	
6.00	Movable Equipment	8,378,872	0				6.00	
7.00	HIT designated Assets	1,376,369	0				7.00	
8.00	Subtotal (sum of lines 1-7)	24,964,075	0				8.00	
9.00	Reconciling Items	-243,221	0				9.00	
10.00	Total (line 8 minus line 9)	25,207,296	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	216,694	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	735,396	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	952,090	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	216,694				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	735,396				2.00
3.00	Total (sum of lines 1-2)	0	952,090				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,208,834	0	15,208,834	0.609229	37,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,755,241	0	9,755,241	0.390771	23,906	2.00
3.00	Total (sum of lines 1-2)	24,964,075	0	24,964,075	1.000000	61,177	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	37,271	216,694	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	23,906	735,396	0	2.00
3.00	Total (sum of lines 1-2)	0	0	61,177	952,090	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	97,400	37,271	0	0	351,365	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	73,429	23,906	0	0	832,731	2.00
3.00	Total (sum of lines 1-2)	170,829	61,177	0	0	1,184,096	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-6	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-6	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-85,797	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,137	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,156	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-917,556			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-745	ADMINISTRATIVE & GENERAL	5.00	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	-64,977	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,396	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,911	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	9	32.00
33.00	NH UTILITIES	B	-85,609	OPERATION OF PLANT	7.00	0	33.00
34.00	MISCELLANEOUS INCOME - A&G	B	31	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MISCELLANEOUS INCOME - OR	B	-1,050	OPERATING ROOM	50.00	0	34.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.02	LOBBYING PORTION OF DUES	A	-5,527	ADMINISTRATIVE & GENERAL	5.00	0	34.02
35.00	PROVIDER BENEFITS	A	-4,162	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PROVIDER BENEFITS	A	-10,350	ADULTS & PEDIATRICS	30.00	0	36.00
37.00	340B RETAIL PHARMACY COSTS	A	-376,166	PHARMACY	15.00	0	37.00
38.00	ADVERTISING	A	-36,991	ADMINISTRATIVE & GENERAL	5.00	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,601,515				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: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 1:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	435,522	435,522	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	47,677	47,677	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	12,199	12,199	0	0	0	3.00
4.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,000	0	36,000	0	0	4.00
5.00	91.00	EMERGENCY	1,543,540	422,158	1,121,382	0	0	5.00
6.00	60.00	LABORATORY	24,000	0	24,000	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,098,938	917,556	1,181,382		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	435,522		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	47,677		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	12,199		3.00
4.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	422,158		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	917,556		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2021 1:44 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					104	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					261	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.68	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	830.84	2,207.48	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.36	64.77	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.18	43.18	32.39			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
1.00							
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					71,751	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					142,978	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					214,729	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					214,729	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					214,729	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					4,491	24.00
25.00	Assistants (line 4 times column 3, line 11)					8,454	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,945	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,073	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,018	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					15,018	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					2,073	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/29/2021 1:44 pm

		Physical Therapy				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.36	64.77	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					214,729	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					15,018	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					229,747	63.00
64.00	Total cost of outside supplier services (from your records)					227,537	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					12,945	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,073	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					15,018	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,073	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,073	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2021 1:44 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					92	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.68	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	733.91	207.60	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.84	61.38	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.92	40.92	30.69			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					60,063	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					12,742	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					72,805	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					72,805	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					72,805	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					3,765	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,765	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					523	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,288	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					4,288	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					523	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2021 1:44 pm	
				Occupational Therapy		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.84	61.38	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					72,805	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					4,288	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					77,093	63.00
64.00	Total cost of outside supplier services (from your records)					63,228	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					3,765	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					523	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					4,288	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					523	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					523	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2021 1:44 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					78	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.68	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	623.01	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.64	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.32	39.32	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					48,994	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					48,994	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					48,994	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					48,994	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					3,067	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,067	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					443	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,510	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,510	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					443	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/29/2021 1:44 pm

		Speech Pathology				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.64	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					48,994	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					3,510	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					52,504	63.00
64.00	Total cost of outside supplier services (from your records)					49,350	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					3,067	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					443	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					3,510	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					443	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					443	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	351,365	351,365			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	832,731	832,731			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,023,924	836	2,024,760		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,040,406	36,818	364,540	3,829,370	5.00
6.00	00600	MAINTENANCE & REPAIRS	468,898	12,053	61,238	552,649	6.00
7.00	00700	OPERATION OF PLANT	282,357	38,637	0	320,994	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,113	3,312	0	74,425	8.00
9.00	00900	HOUSEKEEPING	304,738	1,778	54,671	363,961	9.00
10.00	01000	DIETARY	35,188	21,904	4,129	64,263	10.00
11.00	01100	CAFETERIA	200,553	0	31,156	231,709	11.00
13.00	01300	NURSING ADMINISTRATION	567,085	3,175	116,450	686,710	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	104,421	11,182	21,264	136,867	14.00
15.00	01500	PHARMACY	237,155	4,710	53,628	295,493	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	316,425	4,644	54,462	377,610	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,095,639	27,388	182,405	1,383,288	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	346,298	31,172	39,983	436,032	50.00
53.00	05300	ANESTHESIOLOGY	5,457	456	0	5,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,699	11,993	84,699	776,981	54.00
57.00	05700	CT SCAN	203,416	2,750	23,084	354,538	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	52,702	0	0	52,702	58.00
60.00	06000	LABORATORY	1,680,094	8,984	92,502	1,792,747	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	17,057	0	423	17,480	63.00
65.00	06500	RESPIRATORY THERAPY	287,549	4,492	52,739	357,241	65.00
66.00	06600	PHYSICAL THERAPY	236,466	4,381	1,461	242,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,228	1,221	0	64,449	67.00
68.00	06800	SPEECH PATHOLOGY	49,351	648	0	49,999	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,603	0	0	24,603	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	863,015	0	0	863,015	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	276,008	14,707	27,211	317,926	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,904,458	51,996	484,270	3,444,196	88.00
88.01	08801	RURAL HEALTH CLINIC II	279,736	6,700	43,963	330,399	88.01
91.00	09100	EMERGENCY	2,126,411	11,268	137,279	2,290,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,867,546	317,205	1,930,096	19,738,722	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	465,848	34,160	94,664	594,672	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
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)	20,333,394	351,365	2,024,760	20,333,394	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,829,370					5.00
6.00	00600	MAINTENANCE & REPAIRS	128,229	680,878				6.00
7.00	00700	OPERATION OF PLANT	74,479	87,207	482,680			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,269	7,476	6,078	105,248		8.00
9.00	00900	HOUSEKEEPING	84,448	4,012	3,262	0	455,683	9.00
10.00	01000	DIETARY	14,911	49,439	40,196	0	0	10.00
11.00	01100	CAFETERIA	53,763	0	0	0	15,144	11.00
13.00	01300	NURSING ADMINISTRATION	159,335	7,167	5,827	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	31,757	25,240	20,521	0	11,296	14.00
15.00	01500	PHARMACY	68,562	10,631	8,643	1,802	11,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,615	10,482	8,523	0	4,882	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	320,959	61,819	50,262	14,539	81,181	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	101,171	70,358	57,204	16,977	34,219	50.00
53.00	05300	ANESTHESIOLOGY	1,372	1,029	836	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,280	27,069	22,008	14,773	14,316	54.00
57.00	05700	CT SCAN	82,262	6,207	5,047	1,048	3,269	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,228	0	0	0	0	58.00
60.00	06000	LABORATORY	415,964	20,279	16,487	0	17,627	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,056	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	82,889	10,139	8,244	1,611	15,806	65.00
66.00	06600	PHYSICAL THERAPY	56,222	9,888	8,039	13,710	17,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,954	2,755	2,240	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,601	1,463	1,190	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,709	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	200,242	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	73,767	33,196	26,990	1,543	15,227	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	799,148	117,363	95,420	9,120	72,782	88.00
88.01	08801	RURAL HEALTH CLINIC II	76,661	15,123	12,296	1,575	0	88.01
91.00	09100	EMERGENCY	531,538	25,434	20,679	25,012	110,972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,691,391	603,776	419,992	101,710	426,264	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,979	77,102	62,688	3,538	29,419	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,829,370	680,878	482,680	105,248	455,683	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	168,809					10.00
11.00	01100	CAFETERIA	0	300,616				11.00
13.00	01300	NURSING ADMINISTRATION	0	19,934	878,973			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	6,790	0	232,471		14.00
15.00	01500	PHARMACY	0	8,395	0	1,819	407,137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,469	0	853	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	144,422	39,868	219,790	7,958	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,756	37,246	16,459	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	442	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,509	124,092	2,330	0	54.00
57.00	05700	CT SCAN	0	6,154	33,927	5,686	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	663	0	58.00
60.00	06000	LABORATORY	0	31,038	171,111	156,305	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	134	738	553	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	11,740	64,720	4,993	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	913	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,668	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	407,137	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,387	7,124	39,274	272	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	69,703	0	8,542	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,142	0	88.01
91.00	09100	EMERGENCY	0	34,115	188,075	16,156	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,809	284,729	878,973	231,754	407,137	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,887	0	717	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	168,809	300,616	878,973	232,471	407,137	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	510,434				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,457	2,336,543	0	2,336,543	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,715	797,137	0	797,137	50.00
53.00	05300	ANESTHESIOLOGY	981	10,573	0	10,573	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,281	1,230,639	0	1,230,639	54.00
57.00	05700	CT SCAN	77,623	575,761	0	575,761	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,069	70,662	0	70,662	58.00
60.00	06000	LABORATORY	147,544	2,769,102	0	2,769,102	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	353	23,314	0	23,314	63.00
65.00	06500	RESPIRATORY THERAPY	20,745	578,128	0	578,128	65.00
66.00	06600	PHYSICAL THERAPY	11,163	359,994	0	359,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,111	87,509	0	87,509	67.00
68.00	06800	SPEECH PATHOLOGY	1,651	65,904	0	65,904	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,593	41,573	0	41,573	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,598	1,511,992	0	1,511,992	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,594	546,300	0	546,300	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	38,548	4,654,822	0	4,654,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,167	439,363	0	439,363	88.01
91.00	09100	EMERGENCY	69,241	3,312,076	0	3,312,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	510,434	19,411,392	0	19,411,392	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	922,002	0	922,002	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
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)	510,434	20,333,394	0	20,333,394	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	836	0	836	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,861	36,818	387,606	429,285	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	12,053	10,460	22,513	6.00
7.00	00700	OPERATION OF PLANT	350	38,637	0	38,987	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,312	0	3,312	8.00
9.00	00900	HOUSEKEEPING	221	1,778	2,774	4,773	9.00
10.00	01000	DIETARY	0	21,904	3,042	24,946	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,175	0	3,175	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,363	11,182	0	12,545	14.00
15.00	01500	PHARMACY	0	4,710	0	4,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,059	4,644	2,079	7,782	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,846	27,388	77,856	107,090	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	55,862	31,172	18,579	105,613	50.00
53.00	05300	ANESTHESIOLOGY	722	456	0	1,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410	11,993	160,590	172,993	54.00
57.00	05700	CT SCAN	0	2,750	125,288	128,038	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	41,982	8,984	11,167	62,133	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,412	4,492	12,461	19,365	65.00
66.00	06600	PHYSICAL THERAPY	0	4,381	1,461	5,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,221	0	1,221	67.00
68.00	06800	SPEECH PATHOLOGY	0	648	0	648	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	486	14,707	0	15,193	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,037	51,996	3,472	58,505	88.00
88.01	08801	RURAL HEALTH CLINIC II	457	6,700	0	7,157	88.01
91.00	09100	EMERGENCY	1,273	11,268	15,896	28,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,341	317,205	832,731	1,266,277	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	377	34,160	0	34,537	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
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)	116,718	351,365	832,731	1,300,814	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	429,435					5.00
6.00	00600	MAINTENANCE & REPAIRS	14,380	36,918				6.00
7.00	00700	OPERATION OF PLANT	8,352	4,728	52,067			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,937	405	656	6,310		8.00
9.00	00900	HOUSEKEEPING	9,470	218	352	0	14,836	9.00
10.00	01000	DIETARY	1,672	2,681	4,336	0	0	10.00
11.00	01100	CAFETERIA	6,029	0	0	0	493	11.00
13.00	01300	NURSING ADMINISTRATION	17,868	389	629	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,561	1,369	2,214	0	368	14.00
15.00	01500	PHARMACY	7,689	576	932	108	384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,825	568	919	0	159	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,993	3,352	5,422	872	2,643	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,346	3,815	6,171	1,018	1,114	50.00
53.00	05300	ANESTHESIOLOGY	154	56	90	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,217	1,468	2,374	886	466	54.00
57.00	05700	CT SCAN	9,225	337	544	63	106	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,371	0	0	0	0	58.00
60.00	06000	LABORATORY	46,647	1,100	1,779	0	574	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	455	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,295	550	889	97	515	65.00
66.00	06600	PHYSICAL THERAPY	6,305	536	867	822	578	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,677	149	242	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,301	79	128	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	640	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,456	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,272	1,800	2,911	92	496	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	89,620	6,362	10,293	547	2,370	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,597	820	1,326	94	0	88.01
91.00	09100	EMERGENCY	59,608	1,379	2,231	1,499	3,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	413,962	32,737	45,305	6,098	13,878	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,473	4,181	6,762	212	958	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	429,435	36,918	52,067	6,310	14,836	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	33,637					10.00
11.00	01100	CAFETERIA	0	6,535				11.00
13.00	01300	NURSING ADMINISTRATION	0	433	22,542			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	148	0	20,214		14.00
15.00	01500	PHARMACY	0	182	0	158	14,761	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	445	0	74	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,778	867	5,638	692	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	147	955	1,431	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	38	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	489	3,182	203	0	54.00
57.00	05700	CT SCAN	0	134	870	494	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58	0	58.00
60.00	06000	LABORATORY	0	675	4,388	13,592	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	3	19	48	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	255	1,660	434	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	79	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	580	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,761	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,859	155	1,007	24	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,515	0	743	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	99	0	88.01
91.00	09100	EMERGENCY	0	742	4,823	1,405	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,637	6,190	22,542	20,152	14,761	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	345	0	62	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,637	6,535	22,542	20,214	14,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,794				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	483	191,905	0	191,905	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	804	132,430	0	132,430	50.00
53.00	05300	ANESTHESIOLOGY	38	1,554	0	1,554	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,795	204,108	0	204,108	54.00
57.00	05700	CT SCAN	3,011	142,832	0	142,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197	1,626	0	1,626	58.00
60.00	06000	LABORATORY	5,716	136,642	0	136,642	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	14	539	0	539	63.00
65.00	06500	RESPIRATORY THERAPY	805	33,887	0	33,887	65.00
66.00	06600	PHYSICAL THERAPY	433	15,462	0	15,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	121	3,410	0	3,410	67.00
68.00	06800	SPEECH PATHOLOGY	64	2,220	0	2,220	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178	1,398	0	1,398	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,614	38,831	0	38,831	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	256	35,076	0	35,076	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,495	171,651	0	171,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	84	18,195	0	18,195	88.01
91.00	09100	EMERGENCY	2,686	106,479	0	106,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,794	1,238,245	0	1,238,245	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	62,569	0	62,569	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
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)	19,794	1,300,814	0	1,300,814	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,379					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		808,829				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	165	0	8,703,364			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,270	376,481	1,566,965	-3,829,370	16,504,024	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,380	10,160	263,228	0	552,649	6.00
7.00	00700	OPERATION OF PLANT	7,629	0	0	0	320,994	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	0	0	0	74,425	8.00
9.00	00900	HOUSEKEEPING	351	2,694	235,000	0	363,961	9.00
10.00	01000	DIETARY	4,325	2,955	17,747	0	64,263	10.00
11.00	01100	CAFETERIA	0	0	133,921	0	231,709	11.00
13.00	01300	NURSING ADMINISTRATION	627	0	500,556	0	686,710	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	0	91,402	0	136,867	14.00
15.00	01500	PHARMACY	930	0	230,520	0	295,493	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	2,019	234,104	0	377,610	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,408	75,621	784,062	0	1,383,288	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,155	18,046	171,865	0	436,032	50.00
53.00	05300	ANESTHESIOLOGY	90	0	0	0	5,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	155,981	364,076	0	776,981	54.00
57.00	05700	CT SCAN	543	121,692	99,227	0	354,538	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	52,702	58.00
60.00	06000	LABORATORY	1,774	10,846	397,616	0	1,792,747	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	1,820	0	17,480	63.00
65.00	06500	RESPIRATORY THERAPY	887	12,103	226,695	0	357,241	65.00
66.00	06600	PHYSICAL THERAPY	865	1,419	0	0	242,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	241	0	0	0	64,449	67.00
68.00	06800	SPEECH PATHOLOGY	128	0	0	0	49,999	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	24,603	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	863,015	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	0	116,966	0	317,926	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,267	3,372	2,081,622	0	3,444,196	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	0	188,972	0	330,399	88.01
91.00	09100	EMERGENCY	2,225	15,440	590,091	0	2,290,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,634	808,829	8,296,455	-3,829,370	15,909,352	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	0	406,909	0	594,672	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	351,365	832,731	2,024,760		3,829,370	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.064429	1.029551	0.232641		0.232026	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			836		429,435	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000096		0.026020	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: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	59,564				6.00
7.00	00700	OPERATION OF PLANT	7,629	51,935			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	174,926		8.00
9.00	00900	HOUSEKEEPING	351	351	0	11,013	9.00
10.00	01000	DIETARY	4,325	4,325	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	366	11.00
13.00	01300	NURSING ADMINISTRATION	627	627	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	2,208	0	273	14.00
15.00	01500	PHARMACY	930	930	2,995	285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	118	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,408	5,408	24,164	1,962	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,155	6,155	28,216	827	50.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	2,368	24,553	346	54.00
57.00	05700	CT SCAN	543	543	1,741	79	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	1,774	1,774	0	426	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	887	887	2,678	382	65.00
66.00	06600	PHYSICAL THERAPY	865	865	22,787	429	66.00
67.00	06700	OCCUPATIONAL THERAPY	241	241	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128	128	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	2,904	2,564	368	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,267	10,267	15,157	1,759	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	1,323	2,618	0	88.01
91.00	09100	EMERGENCY	2,225	2,225	41,573	2,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,819	45,190	169,046	10,302	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	6,745	5,880	711	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	680,878	482,680	105,248	455,683	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.431032	9.293925	0.601672	41.376827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,918	52,067	6,310	14,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.619804	1.002542	0.036072	1.347135	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: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,988					11.00
13.00	01300	NURSING ADMINISTRATION	596	4,767				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	203	0	817,781			14.00
15.00	01500	PHARMACY	251	0	6,400	864,411		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	612	0	3,000	0	39,520,627	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,192	1,192	27,993	0	964,444	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	202	202	57,898	0	1,603,799	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,555	0	75,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673	673	8,195	0	3,583,231	54.00
57.00	05700	CT SCAN	184	184	20,003	0	6,009,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	2,332	0	392,458	58.00
60.00	06000	LABORATORY	928	928	549,850	0	11,424,587	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4	4	1,944	0	27,323	63.00
65.00	06500	RESPIRATORY THERAPY	351	351	17,564	0	1,606,153	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,210	0	864,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	240,858	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	0	127,828	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,457	0	355,623	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	864,411	3,220,658	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	213	213	956	0	510,493	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,084	0	30,050	0	2,984,512	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4,017	0	167,746	88.01
91.00	09100	EMERGENCY	1,020	1,020	56,835	0	5,360,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,513	4,767	815,260	864,411	39,520,627	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	475	0	2,521	0	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	300,616	878,973	232,471	407,137	510,434	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.446373	184.387036	0.284270	0.470999	0.012916	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,535	22,542	20,214	14,761	19,794	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.727081	4.728760	0.024718	0.017076	0.000501	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: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,336,543		2,336,543	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	797,137		797,137	0
53.00	05300	ANESTHESIOLOGY	10,573		10,573	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,230,639		1,230,639	0
57.00	05700	CT SCAN	575,761		575,761	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,662		70,662	0
60.00	06000	LABORATORY	2,769,102		2,769,102	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	23,314		23,314	0
65.00	06500	RESPIRATORY THERAPY	578,128	0	578,128	0
66.00	06600	PHYSICAL THERAPY	359,994	0	359,994	0
67.00	06700	OCCUPATIONAL THERAPY	87,509	0	87,509	0
68.00	06800	SPEECH PATHOLOGY	65,904	0	65,904	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,573		41,573	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,511,992		1,511,992	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	546,300		546,300	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,654,822		4,654,822	0
88.01	08801	RURAL HEALTH CLINIC II	439,363		439,363	0
91.00	09100	EMERGENCY	3,312,076		3,312,076	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	535,789		535,789	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	19,947,181	0	19,947,181	0
201.00		Less Observation Beds	535,789		535,789	0
202.00		Total (see instructions)	19,411,392	0	19,411,392	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	740,691		740,691		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,686	1,599,113	1,603,799	0.497030	0.000000
53.00	05300	ANESTHESIOLOGY	1,719	74,239	75,958	0.139195	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,716	3,555,515	3,583,231	0.343444	0.000000
57.00	05700	CT SCAN	137,456	5,872,348	6,009,804	0.095804	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	392,458	392,458	0.180050	0.000000
60.00	06000	LABORATORY	351,713	11,072,874	11,424,587	0.242381	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,543	23,780	27,323	0.853274	0.000000
65.00	06500	RESPIRATORY THERAPY	347,587	1,258,566	1,606,153	0.359946	0.000000
66.00	06600	PHYSICAL THERAPY	56,697	807,605	864,302	0.416514	0.000000
67.00	06700	OCCUPATIONAL THERAPY	41,417	199,441	240,858	0.363322	0.000000
68.00	06800	SPEECH PATHOLOGY	12,635	115,193	127,828	0.515568	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,014	250,609	355,623	0.116902	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	336,034	2,884,624	3,220,658	0.469467	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	510,493	510,493	1.070142	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,984,512	2,984,512		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	167,746	167,746		88.01
91.00	09100	EMERGENCY	37,324	5,323,526	5,360,850	0.617827	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,552	219,201	223,753	2.394556	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,208,784	37,311,843	39,520,627		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,208,784	37,311,843	39,520,627		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
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
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 1:44 pm	
				Title XVIII		Hospital	Cost
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	132,430	1,603,799	0.082573	4,686	387
53.00	05300	ANESTHESIOLOGY	1,554	75,958	0.020459	1,719	35
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,108	3,583,231	0.056962	13,618	776
57.00	05700	CT SCAN	142,832	6,009,804	0.023766	57,133	1,358
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,626	392,458	0.004143	0	0
60.00	06000	LABORATORY	136,642	11,424,587	0.011960	172,754	2,066
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	539	27,323	0.019727	2,798	55
65.00	06500	RESPIRATORY THERAPY	33,887	1,606,153	0.021098	207,819	4,385
66.00	06600	PHYSICAL THERAPY	15,462	864,302	0.017890	7,917	142
67.00	06700	OCCUPATIONAL THERAPY	3,410	240,858	0.014158	5,730	81
68.00	06800	SPEECH PATHOLOGY	2,220	127,828	0.017367	5,189	90
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,398	355,623	0.003931	61,480	242
73.00	07300	DRUGS CHARGED TO PATIENTS	38,831	3,220,658	0.012057	168,954	2,037
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	35,076	510,493	0.068710	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	171,651	2,984,512	0.057514	0	0
88.01	08801	RURAL HEALTH CLINIC II	18,195	167,746	0.108468	0	0
91.00	09100	EMERGENCY	106,479	5,360,850	0.019862	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	44,005	223,753	0.196668	0	0
200.00		Total (lines 50 through 199)	1,090,345	38,779,936		709,797	11,654

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 1:44 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,603,799	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	75,958	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,583,231	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	6,009,804	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	392,458	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,424,587	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	27,323	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,606,153	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	864,302	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	240,858	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,828	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	355,623	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,220,658	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	510,493	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,984,512	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	167,746	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	5,360,850	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	223,753	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	38,779,936		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,686	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,719	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,618	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	57,133	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	172,754	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	2,798	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	207,819	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,917	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,730	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,189	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	61,480	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	168,954	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		709,797	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 1:44 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.497030	0	754,815	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.139195	0	31,105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.343444	0	1,202,395	0	0	54.00
57.00	05700	CT SCAN	0.095804	0	2,293,680	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.180050	0	113,710	0	0	58.00
60.00	06000	LABORATORY	0.242381	0	3,856,412	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.853274	0	6,984	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.359946	0	580,798	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416514	0	288,720	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.363322	0	46,229	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.515568	0	14,884	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116902	0	105,446	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.469467	0	1,834,219	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.070142	0	438,426	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.617827	0	1,611,669	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.394556	0	133,156	0	0	92.00
200.00		Subtotal (see instructions)		0	13,312,648	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	13,312,648	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 1:44 pm

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	375,166	0		50.00
53.00	05300	ANESTHESIOLOGY	4,330	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,955	0		54.00
57.00	05700	CT SCAN	219,744	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,473	0		58.00
60.00	06000	LABORATORY	934,721	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5,959	0		63.00
65.00	06500	RESPIRATORY THERAPY	209,056	0		65.00
66.00	06600	PHYSICAL THERAPY	120,256	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,796	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,674	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,327	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	861,105	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	469,178	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	995,733	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	318,849	0		92.00
200.00		Subtotal (see instructions)	4,984,322	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,984,322	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 1:44 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			683	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			477	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)			323	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			60	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)			134	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			243	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)			44	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)			119	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			169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,336,543	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			2,037	25.00
26.00	Total swing-bed cost (see instructions)			676,990	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,659,553	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)			1,659,553	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)			3,479.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			845,431	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)			845,431	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					226,342	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,071,773	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)					153,082	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					414,018	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					567,100	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)					154	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,479.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					535,789	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 1:44 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	191,905	2,336,543	0.082132	535,789	44,005
91.00	Nursing School cost	0	2,336,543	0.000000	535,789	0
92.00	Allied health cost	0	2,336,543	0.000000	535,789	0
93.00	All other Medical Education	0	2,336,543	0.000000	535,789	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 1:44 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		434,402		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.497030	4,686	2,329	50.00
53.00	05300 ANESTHESIOLOGY	0.139195	1,719	239	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343444	13,618	4,677	54.00
57.00	05700 CT SCAN	0.095804	57,133	5,474	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.180050	0	0	58.00
60.00	06000 LABORATORY	0.242381	172,754	41,872	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.853274	2,798	2,387	63.00
65.00	06500 RESPIRATORY THERAPY	0.359946	207,819	74,804	65.00
66.00	06600 PHYSICAL THERAPY	0.416514	7,917	3,298	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.363322	5,730	2,082	67.00
68.00	06800 SPEECH PATHOLOGY	0.515568	5,189	2,675	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116902	61,480	7,187	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.469467	168,954	79,318	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.070142	0	0	76.00
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
91.00	09100 EMERGENCY	0.617827	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.394556	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		709,797	226,342	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)		709,797		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321 Component CCN: 14-Z321	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 1:44 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.497030	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.139195	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343444	1,540	529	54.00
57.00	05700 CT SCAN	0.095804	1,854	178	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.180050	0	0	58.00
60.00	06000 LABORATORY	0.242381	49,878	12,089	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.853274	745	636	63.00
65.00	06500 RESPIRATORY THERAPY	0.359946	48,296	17,384	65.00
66.00	06600 PHYSICAL THERAPY	0.416514	35,869	14,940	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.363322	26,657	9,685	67.00
68.00	06800 SPEECH PATHOLOGY	0.515568	5,924	3,054	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116902	12,667	1,481	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.469467	69,785	32,762	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.070142	0	0	76.00
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
91.00	09100 EMERGENCY	0.617827	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.394556	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		253,215	92,738	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)		253,215		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 1:44 pm
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,984,322	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)		4,984,322	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,034,165	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)		28,409	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,860,943	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,144,813	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,144,813	30.00
31.00	Primary payer payments		363	31.00
32.00	Subtotal (line 30 minus line 31)		3,144,450	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)		552,910	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		359,392	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		254,635	36.00
37.00	Subtotal (see instructions)		3,503,842	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,503,842	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,559,337	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)		-55,495	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 1:44 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		863,886		3,397,428	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	01/26/2021	22,962	01/26/2021	80,918	3.01
3.02		05/25/2021	31,289	05/25/2021	80,991	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)		54,251		161,909	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)		918,137		3,559,337	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		125,039		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		55,495	6.02
7.00	Total Medicare program liability (see instructions)		1,043,176		3,503,842	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: 14-1321

Period:

Worksheet E-1

Component CCN: 14-Z321

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/29/2021 1:44 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		569,931		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	01/26/2021	6,656		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)		6,656		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)		576,587		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		89,928		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		666,515		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: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/29/2021 1:44 pm	
		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1321

Period:

Worksheet E-2

Component CCN: 14-Z321

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 1:44 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		572,771	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)		93,665	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		163	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)		666,436	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		666,436	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)		666,436	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,113	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		665,323	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)		1,834	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		1,192	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,450	0	18.00
19.00	Total (see instructions)		666,515	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		576,587	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)		89,928	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: 14-1321	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/29/2021 1:44 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,071,773 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,071,773 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,082,491 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,082,491 19.00
20.00	Deductibles (exclude professional component)			70,436 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,012,055 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,012,055 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			47,878 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			31,121 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			28,006 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,043,176 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			1,043,176 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			0 30.03
31.00	Interim payments			918,137 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			125,039 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/29/2021 1:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,115,318	0	0	0	1.00
2.00	Temporary investments	700,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,080,045	0	0	0	4.00
5.00	Other receivable	996,417	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	535,358	0	0	0	7.00
8.00	Prepaid expenses	75,432	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)	11,502,570	0	0	0	11.00
FIXED ASSETS						
12.00	Land	18,401	0	0	0	12.00
13.00	Land improvements	421,431	0	0	0	13.00
14.00	Accumulated depreciation	-152,066	0	0	0	14.00
15.00	Buildings	5,410,832	0	0	0	15.00
16.00	Accumulated depreciation	-4,498,597	0	0	0	16.00
17.00	Leasehold improvements	6,025,291	0	0	0	17.00
18.00	Accumulated depreciation	-4,951,369	0	0	0	18.00
19.00	Fixed equipment	13,088,119	0	0	0	19.00
20.00	Accumulated depreciation	-10,117,002	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	243,221	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,488,261	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	1,269,110	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,269,110	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,259,941	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,499,948	0	0	0	37.00
38.00	Salaries, wages, and fees payable	949,003	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	813,026	0	0	0	40.00
41.00	Deferred income	700,000	0	0	0	41.00
42.00	Accelerated payments	2,810,540	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	766,184	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,538,701	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,417,641	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)	5,417,641	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,956,342	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,303,599	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,303,599	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,259,941	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 1:44 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,071,558		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,232,041				2.00
3.00	Total (sum of line 1 and line 2)		5,303,599		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,303,599		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,303,599		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: 14-1321

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 1:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	740,691		740,691	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)	740,691		740,691	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)	740,691		740,691	17.00
18.00	Ancillary services	1,426,217	28,616,858	30,043,075	18.00
19.00	Outpatient services	41,876	5,542,727	5,584,603	19.00
20.00	RURAL HEALTH CLINIC	0	2,984,512	2,984,512	20.00
20.01	RURAL HEALTH CLINIC II	0	167,746	167,746	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	90,085	296,784	386,869	27.00
27.01	SPECIALTY CLINIC	0	210,632	210,632	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,298,869	37,819,259	40,118,128	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,934,909		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	INTEREST EXPENSE	267,375			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)		267,375		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,667,534		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1321

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 1:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,118,128	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,509,278	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,608,850	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,667,534	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,058,684	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	176,891	6.00
7.00	Income from investments	8,356	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	85,797	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	64,977	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,396	17.00
18.00	Revenue from sale of medical records and abstracts	4,911	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	105,867	22.00
23.00	Governmental appropriations	1,016,549	23.00
24.00	340B RETAIL PHARMACY INCOME	810,906	24.00
24.01	NURSING HOME UTILITIES REIMBURSEMENT	86,354	24.01
24.02	MISCELLANEOUS INCOME	96,819	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.50	COVID-19 PHE Funding	5,099,277	24.50
25.00	Total other income (sum of lines 6-24)	7,558,100	25.00
26.00	Total (line 5 plus line 25)	4,499,416	26.00
27.00	INTEREST EXPENSE	267,375	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	267,375	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,232,041	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	846,326	0	846,326	-13,606	832,720	1.00
2.00	Physician Assistant	113,840	0	113,840	0	113,840	2.00
3.00	Nurse Practitioner	388,934	0	388,934	-2,512	386,422	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	474,651	0	474,651	0	474,651	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,823,751	0	1,823,751	-16,118	1,807,633	10.00
11.00	Physician Services Under Agreement	0	217,514	217,514	0	217,514	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	217,514	217,514	0	217,514	14.00
15.00	Medical Supplies	0	51,716	51,716	0	51,716	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	51,716	51,716	0	51,716	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,823,751	269,230	2,092,981	-16,118	2,076,863	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	16,118	16,118	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	16,118	16,118	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	98,119	98,119	0	98,119	29.00
30.00	Administrative Costs	258,686	455,538	714,224	-866	713,358	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	258,686	553,657	812,343	-866	811,477	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,082,437	822,887	2,905,324	-866	2,904,458	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	832,720	1.00	
2.00	Physician Assistant	0	113,840	2.00	
3.00	Nurse Practitioner	0	386,422	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	474,651	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	1,807,633	10.00	
11.00	Physician Services Under Agreement	0	217,514	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	217,514	14.00	
15.00	Medical Supplies	0	51,716	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			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	51,716	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,076,863	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	16,118	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	16,118	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	98,119	29.00	
30.00	Administrative Costs	0	713,358	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	811,477	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,904,458	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

		RHC II		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	0	0	0	0	0
2.00	Physician Assistant	139,686	0	139,686	-828	138,858
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	47,658	0	47,658	0	47,658
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)	187,344	0	187,344	-828	186,516
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	3,728	3,728	0	3,728
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	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	3,728	3,728	0	3,728
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	187,344	3,728	191,072	-828	190,244
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	828	828
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	828	828
FACILITY OVERHEAD						
29.00	Facility Costs	0	44,306	44,306	0	44,306
30.00	Administrative Costs	1,628	42,730	44,358	0	44,358
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,628	87,036	88,664	0	88,664
32.00	Total facility costs (sum of lines 22, 28 and 31)	188,972	90,764	279,736	0	279,736

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

				RHC II	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0	1.00	
2.00	Physician Assistant	0	138,858	2.00	
3.00	Nurse Practitioner	0	0	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	47,658	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	186,516	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	3,728	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			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	3,728	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	190,244	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	828	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	828	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	44,306	29.00	
30.00	Administrative Costs	0	44,358	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	88,664	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	279,736	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-3469

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	3.02	9,119	4,200	12,684		1.00
2.00	Physician Assistant	0.66	1,660	2,100	1,386		2.00
3.00	Nurse Practitioner	2.32	5,383	2,100	4,872		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.00	16,162		18,942	18,942	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)	6.00	16,162			18,942	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)					2,076,863	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					16,118	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,092,981	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.992299	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					811,477	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,750,364	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,561,841	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,561,841	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,542,112	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,618,975	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-8510

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/29/2021 1:44 pm

				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	0.86	2,031	2,100	1,806		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86	2,031		1,806	2,031	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)	0.86	2,031			2,031	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)					190,244	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					828	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					191,072	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995667	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					88,664	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					159,627	15.00
16.00	Total overhead (sum of lines 14 and 15)					248,291	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					248,291	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					247,215	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					437,459	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/29/2021 1:44 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,618,975	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			32,643	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,586,332	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,942	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)			18,942	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			242.13	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	201.25	8.00
9.00	Rate for Program covered visits (see instructions)	242.13	242.13	201.25	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	3,987	0	1,730	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	965,372	0	348,163	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,313,535		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,121,287		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,686		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		27,747		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.)		964,134		16.04
16.05	Total program cost (see instructions)	0	991,881		16.05
17.00	Primary payer amounts		141		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		80,620		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		203,396		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		991,740		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,474		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,013,214		22.00
23.00	Allowable bad debts (see instructions)		200,209		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		130,136		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		118,698		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,143,350		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		842,077		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)		301,273		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: 14-1321 Component CCN: 14-8510	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/29/2021 1:44 pm	
		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)				437,459 1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				0 2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				437,459 3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				2,031 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)				2,031 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				215.39 7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	213.83	8.00
9.00	Rate for Program covered visits (see instructions)	215.39	215.39	213.83	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	316	0	89	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	68,063	0	19,031	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	87,094		16.00
16.01	Total program charges (see instructions)(from contractor's records)		65,793		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,371		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,786		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.)		59,586		16.04
16.05	Total program cost (see instructions)	0	65,372		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,826		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,919		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		65,372		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		65,372		22.00
23.00	Allowable bad debts (see instructions)		7,806		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,074		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,423		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		70,446		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		64,112		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)		6,334		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: 14-1321

Period:

Worksheet M-4

Component CCN: 14-3469

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/29/2021 1:44 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,807,633	1,807,633	1,807,633	1,807,633	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000095	0.000471	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	172	851	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,948	8,707	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,120	9,558	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,076,863	2,076,863	2,076,863	2,076,863	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,542,112	2,542,112	2,542,112	2,542,112	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002465	0.004602	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,266	11,699	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11,386	21,257	0	0	10.00
11.00	Total number of injections/infusions (from your records)	46	229	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	247.52	92.83	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	32	146	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)	7,921	13,553	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)		32,643			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)		21,474			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/29/2021 1:44 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		852,710	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		01/26/2021	10,633	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)		-10,633	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		842,077	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		301,273	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,143,350	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: 14-1321 Component CCN: 14-8510	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/29/2021 1:44 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		67,247	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		01/26/2021	3,135	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)		-3,135	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		64,112	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		6,334	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		70,446	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00