

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: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/19/2021 12:19 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/19/2021	Time: 12:19 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 HAMILTON MEMORIAL HOSPITAL (14-1326) 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) JUSTIN EPPERSON

Officer or Administrator of Provider(s)

CHIEF FINANCIAL 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	-15,813	221,753	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	61,955	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-4,000		0	10.00
10.01	RURAL HEALTH CLINIC II	0		4,048		0	10.01
200.00	Total	0	46,142	221,801	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: 14-1326		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 12:19 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 611 SOUTH MARSHALL			PO Box:				1.00		
2.00	City: MCLEANSBORO			State: IL		Zip Code: 62859		County: HAMILTON		
		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		HAMILTON MEMORIAL HOSPITAL	141326	99914	1	05/01/2003	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HAMILTON MEMORIAL HOSP SWING BED	14Z326	99914		05/01/2003	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		HAMILTON MEMORIAL FAMILY CLINIC	143477	99914		01/11/2006	N	O	N
15.01	Hospital-Based Health Clinic - RHC I		HAMILTON MEMORIAL FAMILY CLINIC NC	148529	99914		05/06/2013	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)						11			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/19/2021 12:19 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	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: 14-1326		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 12:19 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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/19/2021 12:19 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

MCRIF32 - 16.12.172.4

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		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:	131,840	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
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: 14-1326		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 12:19 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:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	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	Y	Y	N	N				155.00	
156.00	Subprovider - IPF	N	N	N	N				156.00	
157.00	Subprovider - IRF	N	N	N	N				157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF	N	N	N	N				159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N				160.00	
161.00	CMHC		N	N	N				161.00	
								1.00		
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)								N	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: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/19/2021 12:19 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/17/2021	Y 09/17/2021 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/19/2021 12:19 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		N	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.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/19/2021 12:19 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 12:19 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	24,480.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	24,480.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	24,480.00	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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 12:19 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)	775	95	1,020			1.00
2.00	HMO and other (see instructions)	0	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	2,316	0	2,395			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	24			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,091	95	3,439			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)	3,091	95	3,439	0.00	114.64	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	2,242	0	9,353	0.00	11.17	26.00
26.01	RURAL HEALTH CLINIC II	761	0	4,461	0.00	6.39	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	132.20	27.00
28.00	Observation Bed Days		0	209			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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 12:19 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	257	35	343	1.00
2.00 HMO and other (see instructions)			0	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	257	35	343	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: 14-1326 Component CCN: 14-3477		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/19/2021 12:19 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				611 SOUTH MARSHALL		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				MCLEANSBORO		IL 62859		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
						1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from		from		from	
				to		to		to	
				1.00		2.00		3.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
						1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				HAMILTON				2.00
				Tuesday		Wednesday		Thursday	
				to		to		to	
				6.00		7.00		8.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00
						08:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326

Period:

Worksheet S-8

Component CCN: 14-3477

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1326 Component CCN: 14-8529		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/19/2021 12:19 pm	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				1112 OAK STREET				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				CARM		IL 62869		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
						1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
						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	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				WHITE				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00
						08:00		17:00	

Health Financial Systems		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1326	Period: From 07/01/2020	Worksheet S-8
			Component CCN: 14-8529	To 06/30/2021	Date/Time Prepared: 11/19/2021 12:19 pm
			RHC II		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	15:00	09:00	15:00
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/19/2021 12:19 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)		0.480220		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,536,658		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		4,767,323		6.00
7.00	Medicaid cost (line 1 times line 6)		2,289,364		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)		0		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)		35,086		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)		0		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)	33,482	0	33,482	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,079	0	16,079	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	16,079	0	16,079	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,655,022		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		36,810		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		56,630		27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,598,392		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,228,060		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,244,139		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,244,139		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A

Date/Time Prepared:
11/19/2021 12:19 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		977,602	977,602	939,978	1,917,580	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		498,453	498,453	89,767	588,220	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	59,782	1,341,605	1,401,387	0	1,401,387	4.00
5.01	00540	NONPATIENT TELEPHONES	0	44,543	44,543	0	44,543	5.01
5.02	00550	DATA PROCESSING	109,003	771,903	880,906	0	880,906	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	57,028	-8,862	48,166	0	48,166	5.03
5.04	00570	ADMITTING	0	0	0	129,409	129,409	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	358,410	84,669	443,079	-129,409	313,670	5.05
5.06	00590	OTHER ADMIN & GENERAL	334,959	826,201	1,161,160	-44,017	1,117,143	5.06
7.00	00700	OPERATION OF PLANT	120,235	658,346	778,581	-10,370	768,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,803	53,803	0	53,803	8.00
9.00	00900	HOUSEKEEPING	154,432	42,415	196,847	0	196,847	9.00
10.00	01000	DIETARY	0	108,779	108,779	0	108,779	10.00
13.00	01300	NURSING ADMINISTRATION	287,102	34,530	321,632	0	321,632	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	42,258	42,258	-41,428	830	14.00
15.00	01500	PHARMACY	180,829	359,100	539,929	-219,820	320,109	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	209,170	45,879	255,049	0	255,049	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	84,073	84,073	0	84,073	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,480,110	203,625	1,683,735	-3,025	1,680,710	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	182,891	353,774	536,665	-26,664	510,001	50.00
53.00	05300	ANESTHESIOLOGY	0	40,637	40,637	-20,356	20,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,900	316,066	638,966	-15,299	623,667	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	50,250	50,250	0	50,250	58.00
60.00	06000	LABORATORY	513,694	690,967	1,204,661	-18,582	1,186,079	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	73,307	59,892	133,199	-37,577	95,622	65.00
66.00	06600	PHYSICAL THERAPY	556,576	17,264	573,840	-179,534	394,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	164,636	164,636	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,555	2,555	14,358	16,913	68.00
69.00	06900	ELECTROCARDIOLOGY	0	57,471	57,471	0	57,471	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	34,527	34,527	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	14,231	14,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	246,557	246,557	73.00
76.00	03610	SLEEP LAB	0	19,200	19,200	0	19,200	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	202,819	149,061	351,880	-7,083	344,797	76.01
76.02	03020	WOUND CARE	0	101,785	101,785	0	101,785	76.02
76.97	07697	CARDIAC REHABILITATION	46,457	2,187	48,644	0	48,644	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	855,045	576,476	1,431,521	-195	1,431,326	88.00
88.01	08801	RURAL HEALTH CLINIC II	421,206	231,254	652,460	-112,559	539,901	88.01
91.00	09100	EMERGENCY	563,251	1,324,212	1,887,463	36,387	1,923,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		803,932	803,932	-803,932	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,089,206	10,965,905	18,055,111	0	18,055,111	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,089,206	10,965,905	18,055,111	0	18,055,111	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A

Date/Time Prepared:
11/19/2021 12:19 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	-21,181	1,896,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	588,220	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243,069	1,158,318	4.00
5.01	00540	NONPATIENT TELEPHONES	-3,891	40,652	5.01
5.02	00550	DATA PROCESSING	0	880,906	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	48,166	5.03
5.04	00570	ADMITTING	0	129,409	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	313,670	5.05
5.06	00590	OTHER ADMIN & GENERAL	-77,771	1,039,372	5.06
7.00	00700	OPERATION OF PLANT	0	768,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,803	8.00
9.00	00900	HOUSEKEEPING	0	196,847	9.00
10.00	01000	DIETARY	0	108,779	10.00
13.00	01300	NURSING ADMINISTRATION	0	321,632	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	830	14.00
15.00	01500	PHARMACY	-78,930	241,179	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,921	252,128	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-84,073	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-314,466	1,366,244	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-62,790	447,211	50.00
53.00	05300	ANESTHESIOLOGY	0	20,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,623	622,044	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	50,250	58.00
60.00	06000	LABORATORY	-50,731	1,135,348	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	95,622	65.00
66.00	06600	PHYSICAL THERAPY	1,236	395,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	164,636	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,913	68.00
69.00	06900	ELECTROCARDIOLOGY	-13,592	43,879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,858	31,669	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	14,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,473	239,084	73.00
76.00	03610	SLEEP LAB	0	19,200	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	344,797	76.01
76.02	03020	WOUND CARE	-28,693	73,092	76.02
76.97	07697	CARDIAC REHABILITATION	-1,460	47,184	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,431,326	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	539,901	88.01
91.00	09100	EMERGENCY	-671,498	1,252,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,665,784	16,389,327	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,665,784	16,389,327	200.00

RECLASSIFICATIONS

Provider CCN: 14-1326

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

Worksheet A-6

Date/Time Prepared:
11/19/2021 12:19 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	41,896		1.00
	0		0	41,896		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	803,932		1.00
	0		0	803,932		
	C - ADMITTING					
1.00	ADMITTING	5.04	119,470	9,939		1.00
	0		119,470	9,939		
	D - IMPLANTS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	14,231		1.00
	0		0	14,231		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	34,527		1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	3,897		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	0		0	38,424		
	G - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	246,557		1.00
2.00	EMERGENCY	91.00	0	46,130		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	292,687		
	I - RENT & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	105,081		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	78,836		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	183,917		
	J - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	14,162		1.00
2.00		0.00	0	0		2.00
	0		0	14,162		
	K - PT/OT/ST					
1.00	OCCUPATIONAL THERAPY	67.00	164,636	0		1.00
2.00	SPEECH PATHOLOGY	68.00	14,358	0		2.00
	0		178,994	0		
500.00	Grand Total: Increases		298,464	1,399,188		500.00

RECLASSIFICATIONS

Provider CCN: 14-1326

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

Worksheet A-6

Date/Time Prepared:
11/19/2021 12:19 pm

	Decreases						11/19/2021 12:19 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - PROPERTY INSURANCE						1.00
	OTHER ADMIN & GENERAL	5.06	0	41,896	12		
	0		0	41,896			
1.00	B - INTEREST EXPENSE						1.00
	INTEREST EXPENSE	113.00	0	803,932	11		
	0		0	803,932			
1.00	C - ADMITTING						1.00
	CASHIERING/ACCOUNTS RECEIVABLE	5.05	119,470	9,939	0		
	0		119,470	9,939			
1.00	D - IMPLANTS						1.00
	OPERATING ROOM	50.00	0	14,231	0		
	0		0	14,231			
1.00	F - MEDICAL SUPPLIES						1.00
	OPERATING ROOM	50.00	0	7,763	0		
	2.00	ANESTHESIOLOGY	53.00	0	4,744	0	
3.00	RESPIRATORY THERAPY	65.00	0	14,385	0	3.00	
4.00	EMERGENCY	91.00	0	9,743	0	4.00	
5.00	PHARMACY	15.00	0	868	0	5.00	
6.00	PHYSICAL THERAPY	66.00	0	510	0	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12	0	7.00	
8.00	SENIOR ENRICHMENT CENTER	76.01	0	399	0	8.00	
	0		0	38,424			
1.00	G - DRUGS						1.00
	CENTRAL SERVICE & SUPPLY	14.00	0	45,325	0		
	2.00	PHARMACY	15.00	0	218,952	0	
3.00	ADULTS & PEDIATRICS	30.00	0	2,051	0	3.00	
4.00	OPERATING ROOM	50.00	0	3,305	0	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,984	0	5.00	
6.00	RESPIRATORY THERAPY	65.00	0	20,040	0	6.00	
7.00	PHYSICAL THERAPY	66.00	0	30	0	7.00	
	0		0	292,687			
1.00	I - RENT & LEASE EXPENSE						1.00
	OTHER ADMIN & GENERAL	5.06	0	2,121	10		
	2.00	OPERATION OF PLANT	7.00	0	24,532	10	
3.00	ADULTS & PEDIATRICS	30.00	0	974	0	3.00	
4.00	OPERATING ROOM	50.00	0	1,365	0	4.00	
5.00	ANESTHESIOLOGY	53.00	0	15,612	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,303	0	6.00	
7.00	LABORATORY	60.00	0	18,582	0	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	3,152	0	8.00	
9.00	RURAL HEALTH CLINIC	88.00	0	195	0	9.00	
10.00	RURAL HEALTH CLINIC II	88.01	0	105,081	0	10.00	
	0		0	183,917			
1.00	J - UTILITY EXPENSE						1.00
	SENIOR ENRICHMENT CENTER	76.01	0	6,684	0		
	2.00	RURAL HEALTH CLINIC II	88.01	0	7,478	0	
	0		0	14,162			
1.00	K - PT/OT/ST						1.00
	PHYSICAL THERAPY	66.00	178,994	0	0		
	2.00		0.00	0	0	0	
	0		178,994	0			
500.00	Grand Total: Decreases		298,464	1,399,188		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/19/2021 12:19 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	69,760	0	0	0	0	1.00	
2.00	Land Improvements	499,729	0	0	0	0	2.00	
3.00	Buildings and Fixtures	21,717,317	1,012,621	0	1,012,621	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	7,223,640	138,310	0	138,310	0	6.00	
7.00	HIT designated Assets	727,424	135,408	0	135,408	0	7.00	
8.00	Subtotal (sum of lines 1-7)	30,237,870	1,286,339	0	1,286,339	0	8.00	
9.00	Reconciling Items	-536,531	513,444	0	513,444	0	9.00	
10.00	Total (line 8 minus line 9)	30,774,401	772,895	0	772,895	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	69,760	0				1.00	
2.00	Land Improvements	499,729	0				2.00	
3.00	Buildings and Fixtures	22,729,938	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	7,361,950	0				6.00	
7.00	HIT designated Assets	862,832	0				7.00	
8.00	Subtotal (sum of lines 1-7)	31,524,209	0				8.00	
9.00	Reconciling Items	-23,087	0				9.00	
10.00	Total (line 8 minus line 9)	31,547,296	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/19/2021 12:19 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	977,602	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	498,453	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,476,055	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	977,602				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	498,453				2.00
3.00	Total (sum of lines 1-2)	0	1,476,055				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/19/2021 12:19 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	23,299,427	0	23,299,427	0.739096	30,965	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,224,782	0	8,224,782	0.260904	10,931	2.00
3.00	Total (sum of lines 1-2)	31,524,209	0	31,524,209	1.000000	41,896	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	30,965	977,602	105,081	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	10,931	498,453	78,836	2.00
3.00	Total (sum of lines 1-2)	0	0	41,896	1,476,055	183,917	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	782,751	30,965	0	0	1,896,399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,931	0	0	588,220	2.00
3.00	Total (sum of lines 1-2)	782,751	41,896	0	0	2,484,619	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1326

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

Worksheet A-8

Date/Time Prepared:
11/19/2021 12:19 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	-39,460	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,073,470			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2,858	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-7,473	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,921	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-965	OTHER ADMIN & GENERAL	5.06	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	A	-84,073	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	WOMEN'S WELLNESS	B	-45,021	LABORATORY	60.00	0	33.00
33.01	THERAPY PROVIDED TO VNA	B	1,236	PHYSICAL THERAPY	66.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1326

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

Worksheet A-8

Date/Time Prepared:
11/19/2021 12:19 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	
33.02	NURSING CENTER TELEPHONE SERVICES	B	217	NONPATIENT TELEPHONES	5.01	0	33.02
33.03	NURSING CENTER LAB SERVICES	B	-5,710	LABORATORY	60.00	0	33.03
33.04	SELF INSURED DOMESTIC CLAIMS EXPENSE	A	-204,145	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	RETAIL PHARMACY 340B	A	-78,930	PHARMACY	15.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-17,941	ADULTS & PEDIATRICS	30.00	0	33.06
34.00	NON-ALLOWABLE FUNDRAISING	A	-68,177	OTHER ADMIN & GENERAL	5.06	0	34.00
34.01	NON-ALLOWABLE ADVERTISING	A	-1,921	OTHER ADMIN & GENERAL	5.06	0	34.01
34.03	NON-ALLOWABLE FUNDRAISING BENEFITS	A	-6,620	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.03
35.00	NON-ALLOWABLE LOBBYING DUES	A	-6,708	OTHER ADMIN & GENERAL	5.06	0	35.00
35.01	NON-ALLOWABLE PATIENT TELEPHONE EXPE	A	-4,108	NONPATIENT TELEPHONES	5.01	0	35.01
36.00	BOND ISSUANCE COSTS	A	18,279	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
39.00	AMBULANCE COSTS IN ER	A	-2,711	EMERGENCY	91.00	0	39.00
40.00	PHYSICIAN BENEFITS	A	-32,304	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,665,784				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: 14-1326

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

Worksheet A-8-2

Date/Time Prepared:
11/19/2021 12:19 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	296,525	296,525	0	0	0	1.00
2.00	50.00	OPERATING ROOM	62,790	62,790	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,623	1,623	0	0	0	3.00
4.00	60.00	LABORATORY	1,743	0	1,743	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	13,592	13,592	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	30,000	0	30,000	0	0	6.00
7.00	76.02	WOUND CARE	28,693	28,693	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	1,460	1,460	0	0	0	8.00
9.00	91.00	EMERGENCY	48,000	0	48,000	0	0	9.00
10.00	91.00	EMERGENCY	1,231,200	668,787	562,413	0	0	10.00
200.00			1,715,626	1,073,470	642,156		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0	0	6.00
7.00	76.02	WOUND CARE	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	296,525		1.00
2.00	50.00	OPERATING ROOM	0	0	0	62,790		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,623		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	13,592		5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0		6.00
7.00	76.02	WOUND CARE	0	0	0	28,693		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	1,460		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	91.00	EMERGENCY	0	0	0	668,787		10.00
200.00			0	0	0	1,073,470		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 12:19 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					12	1.00
2.00	Line 1 multiplied by 15 hours per week					180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					27	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	46.05	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.89	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.95	38.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					3,587	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)					3,587	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)					3,587	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)					77.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					14,020	22.00
23.00	Total salary equivalency (see instructions)					14,020	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)					1,052	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)					1,052	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)					153	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,205	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)					1,205	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/19/2021 12:19 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)	77.89	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)					14,020	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					1,205	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)					15,225	63.00
64.00	Total cost of outside supplier services (from your records)					2,555	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					1,052	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					153	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,205	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					153	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					153	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: 14-1326

Period:
From 07/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,896,399	1,896,399			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	588,220		588,220		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,158,318	6,975	244	1,165,537	4.00
5.01	00540	NONPATIENT TELEPHONES	40,652	930	0	0	41,582
5.02	00550	DATA PROCESSING	880,906	24,461	169,314	18,856	657
5.03	00560	PURCHASING RECEIVING AND STORES	48,166	52,781	614	9,865	657
5.04	00570	ADMITTING	129,409	3,255	0	20,666	1,094
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	313,670	33,715	0	41,332	2,189
5.06	00590	OTHER ADMIN & GENERAL	1,039,372	208,776	10,063	50,606	3,283
7.00	00700	OPERATION OF PLANT	768,211	165,551	34,831	20,798	438
8.00	00800	LAUNDRY & LINEN SERVICE	53,803	22,229	1,672	0	0
9.00	00900	HOUSEKEEPING	196,847	0	0	26,714	0
10.00	01000	DIETARY	108,779	0	55	0	0
13.00	01300	NURSING ADMINISTRATION	321,632	39,342	1,609	49,663	1,970
14.00	01400	CENTRAL SERVICE & SUPPLY	830	0	0	0	0
15.00	01500	PHARMACY	241,179	27,274	3,130	31,280	438
16.00	01600	MEDICAL RECORDS & LIBRARY	252,128	28,995	4,294	36,183	1,313
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,366,244	310,524	53,260	212,942	9,846
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	447,211	155,786	55,055	31,637	1,532
53.00	05300	ANESTHESIOLOGY	20,281	0	20,321	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,044	102,400	139,129	55,856	3,283
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,250	0	0	0	0
60.00	06000	LABORATORY	1,135,348	40,109	50,130	88,860	2,189
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	95,622	16,276	20,374	12,681	1,313
66.00	06600	PHYSICAL THERAPY	395,542	64,523	4,423	65,315	875
67.00	06700	OCCUPATIONAL THERAPY	164,636	37,854	2,595	28,479	875
68.00	06800	SPEECH PATHOLOGY	16,913	2,139	148	2,484	0
69.00	06900	ELECTROCARDIOLOGY	43,879	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,669	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,231	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	239,084	0	0	0	0
76.00	03610	SLEEP LAB	19,200	8,719	0	0	0
76.01	03950	SENIOR ENRICHMENT CENTER	344,797	79,985	0	35,084	1,532
76.02	03020	WOUND CARE	73,092	1,046	0	0	0
76.97	07697	CARDIAC REHABILITATION	47,184	8,092	0	8,036	219
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,431,326	176,293	4,811	147,907	2,407
88.01	08801	RURAL HEALTH CLINIC II	539,901	44,783	4,473	72,861	2,189
91.00	09100	EMERGENCY	1,252,352	106,911	7,675	97,432	2,845
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,389,327	1,769,724	588,220	1,165,537	41,144
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,208	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	117,467	0	0	438
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	16,389,327	1,896,399	588,220	1,165,537	41,582

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,094,194					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	14,210	126,293				5.03
5.04	00570	ADMITTING	35,526	205	190,155			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	71,052	416	0	462,374		5.05
5.06	00590	OTHER ADMIN & GENERAL	49,736	24,750	0	0	1,386,586	5.06
7.00	00700	OPERATION OF PLANT	14,210	2,702	0	0	1,006,741	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103	0	0	77,807	8.00
9.00	00900	HOUSEKEEPING	0	2,799	0	0	226,360	9.00
10.00	01000	DIETARY	0	1,820	0	0	110,654	10.00
13.00	01300	NURSING ADMINISTRATION	56,841	116	0	0	471,173	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	59	0	0	889	14.00
15.00	01500	PHARMACY	21,315	1,632	0	0	326,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,736	854	0	0	373,503	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	113,682	10,641	88,265	63,520	2,228,924	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	56,841	18,577	33	14,213	780,885	50.00
53.00	05300	ANESTHESIOLOGY	7,105	1,091	8	1,183	49,989	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,631	5,345	6,889	89,756	1,067,333	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	114	5,864	56,228	58.00
60.00	06000	LABORATORY	56,841	40,345	19,073	106,021	1,538,916	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,526	989	2,848	4,457	190,086	65.00
66.00	06600	PHYSICAL THERAPY	42,631	693	11,050	18,722	603,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,315	407	9,941	10,986	277,088	67.00
68.00	06800	SPEECH PATHOLOGY	0	23	359	624	22,690	68.00
69.00	06900	ELECTROCARDIOLOGY	0	654	422	6,158	51,113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,455	7,847	10,182	52,153	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,012	0	2,593	17,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	43,125	39,313	321,522	73.00
76.00	03610	SLEEP LAB	0	0	0	2,429	30,348	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	56,841	977	6	16,025	535,247	76.01
76.02	03020	WOUND CARE	0	228	40	2,637	77,043	76.02
76.97	07697	CARDIAC REHABILITATION	0	52	0	1,114	64,697	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	149,211	1,378	0	17,578	1,930,911	88.00
88.01	08801	RURAL HEALTH CLINIC II	99,472	893	0	7,549	772,121	88.01
91.00	09100	EMERGENCY	99,472	5,077	135	41,450	1,613,349	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)	1,094,194	126,293	190,155	462,374	16,262,214	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,208	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	117,905	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,094,194	126,293	190,155	462,374	16,389,327	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 07/01/2020
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,386,586					5.06
7.00	00700	OPERATION OF PLANT	93,045	1,099,786				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,191	17,462	102,460			8.00
9.00	00900	HOUSEKEEPING	20,921	0	0	247,281		9.00
10.00	01000	DIETARY	10,227	0	0	0	120,881	10.00
13.00	01300	NURSING ADMINISTRATION	43,547	30,906	0	700		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	82	0	0	0	0	14.00
15.00	01500	PHARMACY	30,152	21,426	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,520	22,778	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	206,004	243,944	80,805	77,121	120,881	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,171	122,383	3,763	22,053	0	50.00
53.00	05300	ANESTHESIOLOGY	4,620	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,645	80,444	1,787	12,494	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,197	0	177	0	0	58.00
60.00	06000	LABORATORY	142,230	31,509	0	9,465	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,568	12,786	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	55,802	50,689	8,879	11,320	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,609	29,737	5,209	5,546	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,097	1,680	295	398	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,724	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,820	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,648	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,716	0	0	0	0	73.00
76.00	03610	SLEEP LAB	2,805	6,850	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	49,469	62,836	0	9,503	0	76.01
76.02	03020	WOUND CARE	7,120	822	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	5,979	6,357	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	178,459	138,494	838	41,040	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	71,361	35,181	0	0	0	88.01
91.00	09100	EMERGENCY	149,109	83,988	707	57,641	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)	1,374,838	1,000,272	102,460	247,281	120,881	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	851	7,233	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,897	92,281	0	0	0	192.00
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)	1,386,586	1,099,786	102,460	247,281	120,881	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	546,326					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	971				14.00
15.00	01500	PHARMACY	0	0	377,826			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	430,801		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	338,691	0	0	200,853	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,894	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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	149,292	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	688	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	283	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	377,826	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	30,694	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	132,047	0	0	80,656	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)	546,326	971	377,826	430,801	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	546,326	971	377,826	430,801	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
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					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,497,223	-132,790	3,364,433	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,046,149	0	1,046,149	50.00
53.00	05300	ANESTHESIOLOGY	0	54,609	0	54,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,260,703	0	1,260,703	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61,602	0	61,602	58.00
60.00	06000	LABORATORY	0	1,871,412	0	1,871,412	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	132,172	132,172	64.00
65.00	06500	RESPIRATORY THERAPY	0	220,440	0	220,440	65.00
66.00	06600	PHYSICAL THERAPY	0	730,464	0	730,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	343,189	0	343,189	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,160	0	27,160	68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,837	0	55,837	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,661	0	57,661	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	19,767	0	19,767	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	729,064	0	729,064	73.00
76.00	03610	SLEEP LAB	0	40,003	0	40,003	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	687,749	0	687,749	76.01
76.02	03020	WOUND CARE	0	84,985	618	85,603	76.02
76.97	07697	CARDIAC REHABILITATION	0	77,033	0	77,033	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,289,742	0	2,289,742	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	878,663	0	878,663	88.01
91.00	09100	EMERGENCY	0	2,117,497	0	2,117,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,150,952	0	16,150,952	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	17,292	0	17,292	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	221,083	0	221,083	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,389,327	0	16,389,327	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	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	6,975	244	7,219	4.00
5.01	00540	NONPATIENT TELEPHONES	0	930	0	930	5.01
5.02	00550	DATA PROCESSING	0	24,461	169,314	193,775	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	52,781	614	53,395	5.03
5.04	00570	ADMITTING	0	3,255	0	3,255	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	33,715	0	33,715	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	208,776	10,063	218,839	5.06
7.00	00700	OPERATION OF PLANT	0	165,551	34,831	200,382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,229	1,672	23,901	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	55	55	10.00
13.00	01300	NURSING ADMINISTRATION	0	39,342	1,609	40,951	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	27,274	3,130	30,404	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,995	4,294	33,289	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	310,524	53,260	363,784	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	155,786	55,055	210,841	50.00
53.00	05300	ANESTHESIOLOGY	0	0	20,321	20,321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	102,400	139,129	241,529	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	40,109	50,130	90,239	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,276	20,374	36,650	65.00
66.00	06600	PHYSICAL THERAPY	0	64,523	4,423	68,946	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,854	2,595	40,449	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,139	148	2,287	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	8,719	0	8,719	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	79,985	0	79,985	76.01
76.02	03020	WOUND CARE	0	1,046	0	1,046	76.02
76.97	07697	CARDIAC REHABILITATION	0	8,092	0	8,092	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	176,293	4,811	181,104	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	44,783	4,473	49,256	88.01
91.00	09100	EMERGENCY	0	106,911	7,675	114,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,769,724	588,220	2,357,944	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,208	0	9,208	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	117,467	0	117,467	192.00
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)	0	1,896,399	588,220	2,484,619	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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
5.01	00540	NONPATIENT TELEPHONES	930					5.01
5.02	00550	DATA PROCESSING	15	193,907				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	15	2,518	55,989			5.03
5.04	00570	ADMITTING	24	6,296	91	9,794		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	49	12,591	184	0	46,795	5.05
5.06	00590	OTHER ADMIN & GENERAL	73	8,814	10,972	0	0	5.06
7.00	00700	OPERATION OF PLANT	10	2,518	1,198	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	46	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,241	0	0	9.00
10.00	01000	DIETARY	0	0	807	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	44	10,073	51	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	26	0	0	14.00
15.00	01500	PHARMACY	10	3,777	724	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29	8,814	379	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	220	20,146	4,718	4,544	6,427	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34	10,073	8,236	2	1,438	50.00
53.00	05300	ANESTHESIOLOGY	0	1,259	484	0	120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73	7,555	2,370	355	9,081	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6	593	58.00
60.00	06000	LABORATORY	49	10,073	17,885	983	10,740	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29	6,296	438	147	451	65.00
66.00	06600	PHYSICAL THERAPY	20	7,555	307	569	1,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	3,777	180	512	1,112	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	10	19	63	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	290	22	623	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,088	404	1,030	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	449	0	262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,222	3,978	73.00
76.00	03610	SLEEP LAB	0	0	0	0	246	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	34	10,073	433	0	1,621	76.01
76.02	03020	WOUND CARE	0	0	101	2	267	76.02
76.97	07697	CARDIAC REHABILITATION	5	0	23	0	113	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	54	26,443	611	0	1,778	88.00
88.01	08801	RURAL HEALTH CLINIC II	49	17,628	396	0	764	88.01
91.00	09100	EMERGENCY	64	17,628	2,251	7	4,194	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)	920	193,907	55,989	9,794	46,795	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10	0	0	0	0	192.00
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)	930	193,907	55,989	9,794	46,795	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	239,011					5.06
7.00	00700	OPERATION OF PLANT	16,038	220,275				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,240	3,498	28,685			8.00
9.00	00900	HOUSEKEEPING	3,606	0	0	5,012		9.00
10.00	01000	DIETARY	1,763	0	0	0	2,625	10.00
13.00	01300	NURSING ADMINISTRATION	7,506	6,190	0	14		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14	0	0	0	0	14.00
15.00	01500	PHARMACY	5,197	4,291	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,950	4,562	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,515	48,859	22,621	1,564	2,625	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,440	24,512	1,054	447	0	50.00
53.00	05300	ANESTHESIOLOGY	796	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,004	16,112	500	253	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	896	0	50	0	0	58.00
60.00	06000	LABORATORY	24,516	6,311	0	192	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,028	2,561	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,619	10,152	2,486	229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,414	5,956	1,458	112	0	67.00
68.00	06800	SPEECH PATHOLOGY	361	337	83	8	0	68.00
69.00	06900	ELECTROCARDIOLOGY	814	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	831	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	284	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,122	0	0	0	0	73.00
76.00	03610	SLEEP LAB	483	1,372	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	8,527	12,585	0	193	0	76.01
76.02	03020	WOUND CARE	1,227	165	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	1,031	1,273	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	30,761	27,739	235	832	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,301	7,046	0	0	0	88.01
91.00	09100	EMERGENCY	25,702	16,822	198	1,168	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)	236,986	200,343	28,685	5,012	2,625	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	147	1,449	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,878	18,483	0	0	0	192.00
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)	239,011	220,275	28,685	5,012	2,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	65,136					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	40				14.00
15.00	01500	PHARMACY	0	0	44,597			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	53,247		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,382	0	0	24,826	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,352	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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	18,452	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	12	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	44,597	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,659	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	15,743	0	0	9,969	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)	65,136	40	44,597	53,247	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	65,136	40	44,597	53,247	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
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					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		577,553	0	577,553	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		274,625	0	274,625	50.00
53.00	05300	ANESTHESIOLOGY		22,980	0	22,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		295,178	0	295,178	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		1,545	0	1,545	58.00
60.00	06000	LABORATORY		179,990	0	179,990	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		49,679	0	49,679	65.00
66.00	06600	PHYSICAL THERAPY		102,181	0	102,181	66.00
67.00	06700	OCCUPATIONAL THERAPY		58,166	0	58,166	67.00
68.00	06800	SPEECH PATHOLOGY		3,183	0	3,183	68.00
69.00	06900	ELECTROCARDIOLOGY		1,749	0	1,749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,381	0	3,381	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		1,007	0	1,007	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		55,919	0	55,919	73.00
76.00	03610	SLEEP LAB		10,820	0	10,820	76.00
76.01	03950	SENIOR ENRICHMENT CENTER		117,327	0	117,327	76.01
76.02	03020	WOUND CARE		2,808	0	2,808	76.02
76.97	07697	CARDIAC REHABILITATION		10,587	0	10,587	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		270,473	0	270,473	88.00
88.01	08801	RURAL HEALTH CLINIC II		87,891	0	87,891	88.01
91.00	09100	EMERGENCY		208,935	0	208,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,335,977	0	2,335,977	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		10,804	0	10,804	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		137,838	0	137,838	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,484,619	0	2,484,619	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINES)		
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
			1.00	2.00	4.00	5.01	5.02		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	81,560						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		577,289					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	300	239	6,737,913				4.00
5.01	00540	NONPATIENT TELEPHONES	40	0	0	190			5.01
5.02	00550	DATA PROCESSING	1,052	166,168	109,003	3	154		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,270	603	57,028	3	2		5.03
5.04	00570	ADMITTING	140	0	119,470	5	5		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,450	0	238,940	10	10		5.05
5.06	00590	OTHER ADMIN & GENERAL	8,979	9,876	292,548	15	7		5.06
7.00	00700	OPERATION OF PLANT	7,120	34,184	120,235	2	2		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	1,641	0	0	0		8.00
9.00	00900	HOUSEKEEPING	0	0	154,432	0	0		9.00
10.00	01000	DIETARY	0	54	0	0	0		10.00
13.00	01300	NURSING ADMINISTRATION	1,692	1,579	287,102	9	8		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0		14.00
15.00	01500	PHARMACY	1,173	3,072	180,829	2	3		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	4,214	209,170	6	7		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,355	52,270	1,231,010	45	16		30.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,700	54,032	182,891	7	8		50.00
53.00	05300	ANESTHESIOLOGY	0	19,943	0	0	1		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	136,544	322,900	15	6		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0		58.00
60.00	06000	LABORATORY	1,725	49,198	513,694	10	8		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	700	19,995	73,307	6	5		65.00
66.00	06600	PHYSICAL THERAPY	2,775	4,341	377,582	4	6		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,628	2,547	164,636	4	3		67.00
68.00	06800	SPEECH PATHOLOGY	92	145	14,358	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
76.00	03610	SLEEP LAB	375	0	0	0	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,440	0	202,819	7	8		76.01
76.02	03020	WOUND CARE	45	0	0	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	348	0	46,457	1	0		76.97
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,582	4,722	855,045	11	21		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,926	4,390	421,206	10	14		88.01
91.00	09100	EMERGENCY	4,598	7,532	563,251	13	14		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)	76,112	577,289	6,737,913	188	154		118.00
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,052	0	0	2	0		192.00
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)	1,896,399	588,220	1,165,537	41,582	1,094,194		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.251582	1.018935	0.172982	218.852632	7,105.155844		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,219	930	193,907		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001071	4.894737	1,259.136364		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: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,776,044					5.03
5.04	00570	ADMITTING	2,881	8,819,224				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,850	0	33,632,426			5.05
5.06	00590	OTHER ADMIN & GENERAL	348,057	0	0	-1,386,586	15,002,741	5.06
7.00	00700	OPERATION OF PLANT	37,992	0	0	0	1,006,741	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,446	0	0	0	77,807	8.00
9.00	00900	HOUSEKEEPING	39,365	0	0	0	226,360	9.00
10.00	01000	DIETARY	25,599	0	0	0	110,654	10.00
13.00	01300	NURSING ADMINISTRATION	1,633	0	0	0	471,173	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	830	0	0	0	889	14.00
15.00	01500	PHARMACY	22,953	0	0	0	326,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,010	0	0	0	373,503	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	149,645	4,093,614	4,620,317	0	2,228,924	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	261,246	1,518	1,033,853	0	780,885	50.00
53.00	05300	ANESTHESIOLOGY	15,348	381	86,052	0	49,989	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,166	319,496	6,528,628	0	1,067,333	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,277	426,559	0	56,228	58.00
60.00	06000	LABORATORY	567,378	884,587	7,711,951	0	1,538,916	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,903	132,071	324,197	0	190,086	65.00
66.00	06600	PHYSICAL THERAPY	9,750	512,505	1,361,781	0	603,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,722	461,072	799,131	0	277,088	67.00
68.00	06800	SPEECH PATHOLOGY	325	16,660	45,380	0	22,690	68.00
69.00	06900	ELECTROCARDIOLOGY	9,192	19,575	447,896	0	51,113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,527	363,924	740,638	0	52,153	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,231	0	188,599	0	17,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,000,144	2,859,558	0	321,522	73.00
76.00	03610	SLEEP LAB	0	0	176,705	0	30,348	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	13,746	256	1,165,652	0	535,247	76.01
76.02	03020	WOUND CARE	3,202	1,860	191,826	0	77,043	76.02
76.97	07697	CARDIAC REHABILITATION	727	0	81,016	0	64,697	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	19,377	0	1,278,563	0	1,930,911	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,552	0	549,127	0	772,121	88.01
91.00	09100	EMERGENCY	71,391	6,284	3,014,997	0	1,613,349	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)	1,776,044	8,819,224	33,632,426	-1,386,586	14,875,628	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,208	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	117,905	192.00
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)	126,293	190,155	462,374		1,386,586	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.071109	0.021561	0.013748		0.092422	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,989	9,794	46,795		239,011	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.031525	0.001111	0.001391		0.015931	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: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
		7.00	8.00	9.00	10.00	13.00	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	60,209				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	84,320			8.00
9.00	00900	HOUSEKEEPING	0	0	13,063		9.00
10.00	01000	DIETARY	0	0	0	11,534	10.00
13.00	01300	NURSING ADMINISTRATION	1,692	0	37	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	80,488	14.00
15.00	01500	PHARMACY	1,173	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,355	66,497	4,074	11,534	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,700	3,097	1,165	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	1,471	660	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	146	0	0	58.00
60.00	06000	LABORATORY	1,725	0	500	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,775	7,307	598	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,628	4,287	293	0	67.00
68.00	06800	SPEECH PATHOLOGY	92	243	21	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	375	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,440	0	502	0	76.01
76.02	03020	WOUND CARE	45	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	348	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,582	690	2,168	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,926	0	0	0	88.01
91.00	09100	EMERGENCY	4,598	582	3,045	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				19,454	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,761	84,320	13,063	11,534	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,052	0	0	0	192.00
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)	1,099,786	102,460	247,281	120,881	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.266140	1.215133	18.929878	10.480406	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	220,275	28,685	5,012	2,625	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.658506	0.340192	0.383679	0.227588	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: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	48,758					14.00
15.00	01500	PHARMACY	0	246,557				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	38,350			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	17,880	0	0	30.00
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
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	13,290	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,527	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,231	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	246,557	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	7,180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,758	246,557	38,350	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	971	377,826	430,801	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019915	1.532408	11.233403	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40	44,597	53,247	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000820	0.180879	1.388449	0.000000	0.000000	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

Provider CCN: 14-1326

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

Worksheet B-2

Date/Time Prepared:
11/19/2021 12:19 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY & OP SERVICES		1	30.00	-132,790
8.00		IV THERAPY		1	64.00	132,172
9.00		OP SERVICES		1	76.02	618

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 12:19 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,364,433		3,364,433	0		0	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,046,149		1,046,149	0		0	50.00
53.00	05300	ANESTHESIOLOGY	54,609		54,609	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,260,703		1,260,703	0		0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	61,602		61,602	0		0	58.00
60.00	06000	LABORATORY	1,871,412		1,871,412	0		0	60.00
64.00	06400	INTRAVENOUS THERAPY	132,172		132,172	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	220,440	0	220,440	0		0	65.00
66.00	06600	PHYSICAL THERAPY	730,464	0	730,464	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,189	0	343,189	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	27,160	0	27,160	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	55,837		55,837	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,661		57,661	0		0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	19,767		19,767	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	729,064		729,064	0		0	73.00
76.00	03610	SLEEP LAB	40,003		40,003	0		0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	687,749		687,749	0		0	76.01
76.02	03020	WOUND CARE	85,603		85,603	0		0	76.02
76.97	07697	CARDIAC REHABILITATION	77,033		77,033	0		0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,289,742		2,289,742	0		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	878,663		878,663	0		0	88.01
91.00	09100	EMERGENCY	2,117,497		2,117,497	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,795		193,795			0	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	16,344,747	0	16,344,747	0		0	200.00
201.00		Less Observation Beds	193,795		193,795			0	201.00
202.00		Total (see instructions)	16,150,952	0	16,150,952	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 12:19 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				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,918,319		3,918,319			30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,518	1,032,335	1,033,853	1.011893	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	381	85,671	86,052	0.634605	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,496	6,209,132	6,528,628	0.193104	0.000000	54.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,277	421,282	426,559	0.144416	0.000000	58.00	
60.00	06000	LABORATORY	884,587	6,827,364	7,711,951	0.242664	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	172,849	307,065	479,914	0.275408	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	132,071	192,126	324,197	0.679957	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	512,505	849,276	1,361,781	0.536403	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	461,072	338,059	799,131	0.429453	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	16,660	28,720	45,380	0.598502	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	19,575	428,321	447,896	0.124665	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	363,924	376,714	740,638	0.077853	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	188,599	188,599	0.104810	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,000,144	859,414	2,859,558	0.254957	0.000000	73.00	
76.00	03610	SLEEP LAB	0	176,705	176,705	0.226383	0.000000	76.00	
76.01	03950	SENIOR ENRICHMENT CENTER	256	1,165,396	1,165,652	0.590012	0.000000	76.01	
76.02	03020	WOUND CARE	1,860	189,966	191,826	0.446253	0.000000	76.02	
76.97	07697	CARDIAC REHABILITATION	0	81,016	81,016	0.950837	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	1,278,563	1,278,563			88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	549,127	549,127			88.01	
91.00	09100	EMERGENCY	6,284	3,008,713	3,014,997	0.702321	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,446	219,638	222,084	0.872620	0.000000	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	8,819,224	24,813,202	33,632,426			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	8,819,224	24,813,202	33,632,426			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 12:19 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
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03610 SLEEP LAB	0.000000			76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.000000			76.01
76.02	03020 WOUND CARE	0.000000			76.02
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	274,625	1,033,853	0.265633	203	54
53.00	05300	ANESTHESIOLOGY	22,980	86,052	0.267048	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,178	6,528,628	0.045213	152,709	6,904
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,545	426,559	0.003622	2,639	10
60.00	06000	LABORATORY	179,990	7,711,951	0.023339	436,812	10,195
64.00	06400	INTRAVENOUS THERAPY	0	479,914	0.000000	17,373	0
65.00	06500	RESPIRATORY THERAPY	49,679	324,197	0.153237	54,884	8,410
66.00	06600	PHYSICAL THERAPY	102,181	1,361,781	0.075035	33,167	2,489
67.00	06700	OCCUPATIONAL THERAPY	58,166	799,131	0.072787	18,975	1,381
68.00	06800	SPEECH PATHOLOGY	3,183	45,380	0.070141	2,526	177
69.00	06900	ELECTROCARDIOLOGY	1,749	447,896	0.003905	9,503	37
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,381	740,638	0.004565	101,605	464
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,007	188,599	0.005339	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	55,919	2,859,558	0.019555	574,654	11,237
76.00	03610	SLEEP LAB	10,820	176,705	0.061232	0	0
76.01	03950	SENIOR ENRICHMENT CENTER	117,327	1,165,652	0.100654	0	0
76.02	03020	WOUND CARE	2,808	191,826	0.014638	0	0
76.97	07697	CARDIAC REHABILITATION	10,587	81,016	0.130678	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	270,473	1,278,563	0.211545	0	0
88.01	08801	RURAL HEALTH CLINIC II	87,891	549,127	0.160056	0	0
91.00	09100	EMERGENCY	208,935	3,014,997	0.069299	887	61
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,268	222,084	0.149799	0	0
200.00		Total (lines 50 through 199)	1,791,692	29,714,107		1,405,937	41,419

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 12:19 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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 12:19 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	1,033,853	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	86,052	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,528,628	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	426,559	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	7,711,951	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	479,914	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	324,197	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,361,781	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	799,131	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	45,380	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	447,896	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	740,638	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	188,599	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,859,558	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	176,705	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	1,165,652	0.000000	76.01
76.02	03020	WOUND CARE	0	0	0	191,826	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	81,016	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,278,563	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	549,127	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	3,014,997	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	222,084	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	29,714,107		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 12:19 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	203	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	152,709	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,639	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	436,812	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	17,373	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	54,884	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	33,167	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,975	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,526	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,503	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	101,605	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	574,654	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000	0	0	0	0	76.01
76.02	03020	WOUND CARE	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	887	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)		1,405,937	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/19/2021 12:19 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	1.011893	0	497,724	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.634605	0	34,605	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193104	0	2,853,296	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.144416	0	168,053	0	0	58.00
60.00	06000	LABORATORY	0.242664	0	3,419,777	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.275408	0	196,931	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.679957	0	90,643	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.536403	0	318,681	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.429453	0	136,874	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.598502	0	4,814	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124665	0	234,122	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077853	0	151,558	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.104810	0	134,338	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254957	0	442,946	0	0	73.00
76.00	03610	SLEEP LAB	0.226383	0	63,235	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.590012	0	1,165,396	0	0	76.01
76.02	03020	WOUND CARE	0.446253	0	155,810	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.950837	0	52,013	0	0	76.97
	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	0.702321	0	1,293,874	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872620	0	169,902	0	0	92.00
200.00		Subtotal (see instructions)		0	11,584,592	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	11,584,592	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/19/2021 12:19 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	503,643	0		50.00
53.00	05300	ANESTHESIOLOGY	21,961	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	550,983	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,270	0		58.00
60.00	06000	LABORATORY	829,857	0		60.00
64.00	06400	INTRAVENOUS THERAPY	54,236	0		64.00
65.00	06500	RESPIRATORY THERAPY	61,633	0		65.00
66.00	06600	PHYSICAL THERAPY	170,941	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	58,781	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,881	0		68.00
69.00	06900	ELECTROCARDIOLOGY	29,187	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,799	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,080	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,932	0		73.00
76.00	03610	SLEEP LAB	14,315	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	687,598	0		76.01
76.02	03020	WOUND CARE	69,531	0		76.02
76.97	07697	CARDIAC REHABILITATION	49,456	0		76.97
	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	908,715	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,260	0		92.00
200.00		Subtotal (see instructions)	4,325,059	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,325,059	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/19/2021 12:19 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,229	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,020	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,117	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)			1,278	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			24	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			775	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)			1,038	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)			1,278	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)			3,364,433	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,073	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			2,224,837	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,139,596	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)			1,139,596	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)			927.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			718,619	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)			718,619	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1326

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

Worksheet D-1

Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		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)					361,860	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,080,479	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)					962,486	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,185,026	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,147,512	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)					209	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					927.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					193,795	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1326

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

Worksheet D-1

Date/Time Prepared:
11/19/2021 12:19 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	577,553	3,364,433	0.171664	193,795	33,268
91.00	Nursing School cost	0	3,364,433	0.000000	193,795	0
92.00	Allied health cost	0	3,364,433	0.000000	193,795	0
93.00	All other Medical Education	0	3,364,433	0.000000	193,795	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/19/2021 12:19 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		1,090,034		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.011893	203	205	50.00
53.00	05300 ANESTHESIOLOGY	0.634605	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193104	152,709	29,489	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.144416	2,639	381	58.00
60.00	06000 LABORATORY	0.242664	436,812	105,999	60.00
64.00	06400 INTRAVENOUS THERAPY	0.275408	17,373	4,785	64.00
65.00	06500 RESPIRATORY THERAPY	0.679957	54,884	37,319	65.00
66.00	06600 PHYSICAL THERAPY	0.536403	33,167	17,791	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.429453	18,975	8,149	67.00
68.00	06800 SPEECH PATHOLOGY	0.598502	2,526	1,512	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124665	9,503	1,185	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077853	101,605	7,910	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.104810	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254957	574,654	146,512	73.00
76.00	03610 SLEEP LAB	0.226383	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.590012	0	0	76.01
76.02	03020 WOUND CARE	0.446253	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.950837	0	0	76.97
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	0.702321	887	623	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.872620	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,405,937	361,860	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,405,937		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326 Component CCN: 14-Z326	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/19/2021 12:19 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	1.011893	117	118	50.00
53.00	05300 ANESTHESIOLOGY	0.634605	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193104	83,605	16,144	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.144416	0	0	58.00
60.00	06000 LABORATORY	0.242664	247,261	60,001	60.00
64.00	06400 INTRAVENOUS THERAPY	0.275408	10,140	2,793	64.00
65.00	06500 RESPIRATORY THERAPY	0.679957	54,828	37,281	65.00
66.00	06600 PHYSICAL THERAPY	0.536403	465,733	249,821	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.429453	422,749	181,551	67.00
68.00	06800 SPEECH PATHOLOGY	0.598502	12,519	7,493	68.00
69.00	06900 ELECTROCARDIOLOGY	0.124665	4,751	592	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.077853	217,545	16,937	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.104810	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254957	1,171,021	298,560	73.00
76.00	03610 SLEEP LAB	0.226383	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.590012	0	0	76.01
76.02	03020 WOUND CARE	0.446253	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.950837	0	0	76.97
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	0.702321	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.872620	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,690,269	871,291	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,690,269		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/19/2021 12:19 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,325,059 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)			4,325,059 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)			4,368,310 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)			26,917 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,628,608 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,712,785 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,712,785 30.00
31.00	Primary payer payments			196 31.00
32.00	Subtotal (line 30 minus line 31)			2,712,589 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)			21,346 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			13,875 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			21,346 36.00
37.00	Subtotal (see instructions)			2,726,464 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,726,464 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			2,504,711 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)			221,753 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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/19/2021 12:19 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		869,644		2,325,817	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	02/18/2021	17,498	02/18/2021	134,430	3.01
3.02			0	06/03/2021	44,464	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/03/2021	944		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)		16,554		178,894	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)		886,198		2,504,711	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		221,753	6.01
6.02	SETTLEMENT TO PROGRAM		15,813		0	6.02
7.00	Total Medicare program liability (see instructions)		870,385		2,726,464	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: 14-1326

Period:

Worksheet E-1

Component CCN: 14-Z326

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/19/2021 12:19 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,849,500		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	02/18/2021	5,772		0	3.01
3.02		06/03/2021	2,873		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)		8,645		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,858,145		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		61,955		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,920,100		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: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/19/2021 12:19 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: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-Z326		Date/Time Prepared: 11/19/2021 12:19 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)		2,168,987	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)		880,004	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		2,316	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)		3,048,991	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,048,991	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)		3,048,991	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		130,136	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,918,855	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)		1,916	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		1,245	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,916	0	18.00
19.00	Total (see instructions)		2,920,100	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		2,858,145	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)		61,955	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: 14-1326	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/19/2021 12:19 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,080,479	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)		1,080,479	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,091,284	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)		1,091,284	19.00
20.00	Deductibles (exclude professional component)		233,390	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		857,894	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		857,894	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		19,217	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		12,491	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,217	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		870,385	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)		870,385	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		886,198	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)		-15,813	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: 14-1326

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

Worksheet G

Date/Time Prepared:
11/19/2021 12:19 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	9,704,701	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,586,219	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	370,529	0	0	0	7.00
8.00	Prepaid expenses	164,300	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)	11,825,749	0	0	0	11.00
FIXED ASSETS						
12.00	Land	69,760	0	0	0	12.00
13.00	Land improvements	499,729	0	0	0	13.00
14.00	Accumulated depreciation	-350,519	0	0	0	14.00
15.00	Buildings	22,729,938	0	0	0	15.00
16.00	Accumulated depreciation	-14,079,289	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,224,782	0	0	0	23.00
24.00	Accumulated depreciation	-6,587,015	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	23,087	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,530,473	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,196,791	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	104,942	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,301,733	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,657,955	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	673,760	0	0	0	37.00
38.00	Salaries, wages, and fees payable	490,880	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	687,996	0	0	0	40.00
41.00	Deferred income	2,977,782	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	230,371	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,060,789	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,703,004	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)	16,703,004	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,763,793	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,894,162	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)	3,894,162	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,657,955	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1326

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

Worksheet G-1

Date/Time Prepared:
11/19/2021 12:19 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		803,286		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,090,876				2.00
3.00	Total (sum of line 1 and line 2)		3,894,162		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)		3,894,162		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)		3,894,162		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: 14-1326

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2021 12:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,284,506		1,284,506	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,612,909		2,612,909	5.00
6.00	Swing bed - NF	20,903		20,903	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,918,318		3,918,318	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)	3,918,318		3,918,318	17.00
18.00	Ancillary services	4,892,175	19,772,058	24,664,233	18.00
19.00	Outpatient services	8,730	3,258,422	3,267,152	19.00
20.00	RURAL HEALTH CLINIC	0	1,302,295	1,302,295	20.00
20.01	RURAL HEALTH CLINIC II	0	558,104	558,104	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 CHARGES	436,252	684,020	1,120,272	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,255,475	25,574,899	34,830,374	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,055,111		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	803,932			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)		803,932		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,251,179		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1326

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

Worksheet G-3

Date/Time Prepared:
11/19/2021 12:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,830,374	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,818,842	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,011,532	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,251,179	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-239,647	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	375,822	6.00
7.00	Income from investments	404	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	2,858	16.00
17.00	Revenue from sale of drugs to other than patients	7,473	17.00
18.00	Revenue from sale of medical records and abstracts	2,921	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	965	21.00
22.00	Rental of hospital space	24,256	22.00
23.00	Governmental appropriations	703,440	23.00
24.00	340B DRUG REVENUE	390,819	24.00
24.01	WELLNESS PROGRAMS	45,021	24.01
24.02	MISCELLANEOUS INCOME	112,242	24.02
24.03	GAIN ON SALE OF FIXED ASSET	2,388	24.03
24.50	COVID-19 PHE Funding	2,465,846	24.50
25.00	Total other income (sum of lines 6-24)	4,134,455	25.00
26.00	Total (line 5 plus line 25)	3,894,808	26.00
27.00	INTEREST EXPENSE	803,932	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	803,932	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,090,876	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-3477

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	252,071	0	252,071	-35,322	216,749	1.00
2.00	Physician Assistant	13,992	0	13,992	0	13,992	2.00
3.00	Nurse Practitioner	324,280	0	324,280	-1,510	322,770	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	147,345	0	147,345	0	147,345	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	94,670	94,670	0	94,670	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)	737,688	94,670	832,358	-36,832	795,526	10.00
11.00	Physician Services Under Agreement	0	401,549	401,549	0	401,549	11.00
12.00	Physician Supervision Under Agreement	0	6,000	6,000	0	6,000	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	407,549	407,549	0	407,549	14.00
15.00	Medical Supplies	0	41,466	41,466	0	41,466	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,466	41,466	0	41,466	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	737,688	543,685	1,281,373	-36,832	1,244,541	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	36,832	36,832	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	36,832	36,832	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	188	188	0	188	29.00
30.00	Administrative Costs	117,357	32,603	149,960	-195	149,765	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	117,357	32,791	150,148	-195	149,953	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	855,045	576,476	1,431,521	-195	1,431,326	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-3477

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	216,749	1.00
2.00	Physician Assistant	0	13,992	2.00
3.00	Nurse Practitioner	0	322,770	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	147,345	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	94,670	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	795,526	10.00
11.00	Physician Services Under Agreement	0	401,549	11.00
12.00	Physician Supervision Under Agreement	0	6,000	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	407,549	14.00
15.00	Medical Supplies	0	41,466	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,466	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,244,541	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	36,832	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	36,832	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	188	29.00
30.00	Administrative Costs	0	149,765	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	149,953	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,431,326	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-8529

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	0	0	0	0	0
3.00	Nurse Practitioner	272,528	0	272,528	-1,584	270,944
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	71,531	0	71,531	0	71,531
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	673	0	673	0	673
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	344,732	0	344,732	-1,584	343,148
11.00	Physician Services Under Agreement	0	76,125	76,125	0	76,125
12.00	Physician Supervision Under Agreement	0	6,000	6,000	0	6,000
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	82,125	82,125	0	82,125
15.00	Medical Supplies	0	7,080	7,080	0	7,080
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	7,080	7,080	0	7,080
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	344,732	89,205	433,937	-1,584	432,353
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	1,584	1,584
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,584	1,584
FACILITY OVERHEAD						
29.00	Facility Costs	0	112,834	112,834	-112,559	275
30.00	Administrative Costs	76,474	29,215	105,689	0	105,689
31.00	Total Facility Overhead (sum of lines 29 and 30)	76,474	142,049	218,523	-112,559	105,964
32.00	Total facility costs (sum of lines 22, 28 and 31)	421,206	231,254	652,460	-112,559	539,901

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-8529

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	0	2.00
3.00	Nurse Practitioner	0	270,944	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	71,531	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	673	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	343,148	10.00
11.00	Physician Services Under Agreement	0	76,125	11.00
12.00	Physician Supervision Under Agreement	0	6,000	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	82,125	14.00
15.00	Medical Supplies	0	7,080	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,080	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	432,353	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,584	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,584	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	275	29.00
30.00	Administrative Costs	0	105,689	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	105,964	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	539,901	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326

Period:

Worksheet M-2

Component CCN: 14-3477

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	1.32	2,970	4,200	5,544		1.00
2.00	Physician Assistant	0.06	209	2,100	126		2.00
3.00	Nurse Practitioner	2.30	4,702	2,100	4,830		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.68	7,881		10,500	10,500	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	0.52	1,472			1,472	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.20	9,353			11,972	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)					1,244,541	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					36,832	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,281,373	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.971256	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					149,953	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					858,416	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,008,369	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,008,369	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					979,384	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,223,925	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326

Period:

Worksheet M-2

Component CCN: 14-8529

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 12:19 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	0.24	356	4,200	1,008		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.83	4,105	2,100	3,843		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.07	4,461		4,851	4,851	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)	2.07	4,461			4,851	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)					432,353	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,584	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					433,937	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996350	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					105,964	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					338,762	15.00
16.00	Total overhead (sum of lines 14 and 15)					444,726	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					444,726	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					443,103	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					875,456	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/19/2021 12:19 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)			2,223,925	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			38,094	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,185,831	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,972	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)			11,972	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			182.58	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	203.35	8.00
9.00	Rate for Program covered visits (see instructions)	182.58	182.58	182.58	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,377	757	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	251,413	138,213	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	63	45	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	11,503	8,216	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	11,503	8,216	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	409,345		16.00
16.01	Total program charges (see instructions)(from contractor's records)		286,709		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,298		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,558		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.)		279,494		16.04
16.05	Total program cost (see instructions)	0	297,052		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,420		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,400		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		297,052		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,238		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		310,290		22.00
23.00	Allowable bad debts (see instructions)		11,150		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		7,248		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,150		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)		317,538		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		321,538		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)		-4,000		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

Health Financial Systems		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-8529		Period: From 07/01/2020 To 06/30/2021 Worksheet M-3 Date/Time Prepared: 11/19/2021 12:19 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)			875,456	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			6,502	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			868,954	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,851	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,851	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			179.13	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	187.72	8.00
9.00	Rate for Program covered visits (see instructions)	179.13	179.13	179.13	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	567	194	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	101,567	34,751	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	136,318		16.00
16.01	Total program charges (see instructions)(from contractor's records)		97,742		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,002		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,950		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.)		86,897		16.04
16.05	Total program cost (see instructions)	0	100,847		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,747		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,799		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		100,847		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,417		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		102,264		22.00
23.00	Allowable bad debts (see instructions)		3,001		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,951		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,001		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)		104,215		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		100,167		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)		4,048		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: 14-1326

Period:

Worksheet M-4

Component CCN: 14-3477

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/19/2021 12:19 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)	795,526	795,526	795,526	795,526	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000719	0.003667	0.004150	0.001603	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	572	2,917	3,301	1,275	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,960	6,294	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,532	9,211	3,301	1,275	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,244,541	1,244,541	1,244,541	1,244,541	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	979,384	979,384	979,384	979,384	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006052	0.007401	0.002652	0.001024	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,927	7,248	2,597	1,003	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13,459	16,459	5,898	2,278	10.00
11.00	Total number of injections/infusions (from your records)	70	357	404	13	11.00
12.00	Cost per injection/infusion (line 10/line 11)	192.27	46.10	14.60	175.23	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	20	116	173	2	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			20	5	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)	3,845	5,348	2,818	1,227	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)		38,094			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)		13,238			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1326

Period:

Worksheet M-4

Component CCN: 14-8529

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/19/2021 12:19 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	343,148	343,148	343,148	343,148	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000098	0.002160	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	34	741	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	497	1,939	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	531	2,680	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	432,353	432,353	432,353	432,353	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	443,103	443,103	443,103	443,103	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001228	0.006199	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	544	2,747	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,075	5,427	0	0	10.00
11.00	Total number of injections/infusions (from your records)	5	110	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	215.00	49.34	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	20	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)	430	987	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)		6,502			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,417			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/19/2021 12:19 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		333,138	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		02/18/2021	7,205	3.50
3.51		06/03/2021	4,395	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)		-11,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		321,538	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)		0	6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		4,000	6.02
7.00	Total Medicare program liability (see instructions)		317,538	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: 14-1326 Component CCN: 14-8529	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/19/2021 12:19 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		85,295	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		02/18/2021	11,850	3.01
3.02		06/03/2021	3,022	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		14,872	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		100,167	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		4,048	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		104,215	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00