

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 9:54 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/27/2022	Time: 9:54 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (14-1327) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Karissa Turner	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Karissa Turner		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-424,812	-701,088	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	211,717	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		4,193		0	10.00
10.01 RURAL HEALTH CLINIC II	0		61,910		0	10.01
10.02 RURAL HEALTH CLINIC III	0		103,142		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		52,633		0	10.03
10.04 RURAL HEALTH CLINIC V	0		-15,218		0	10.04
10.05 RURAL HEALTH CLINIC VI	0		-46,590		0	10.05
200.00 Total	0	-213,095	-541,018	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: 14-1327		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:54 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1418 COLLEGE DRIVE			PO Box:				1.00		
2.00	City: MT. CARMEL			State: IL		Zip Code: 62863		County: WABASH		
		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		WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	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		WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N
15.01	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE	148568	14999		08/09/2016	N	O	N
15.02	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - COLLEGE DR	148579	14999		10/01/2017	N	O	N
15.03	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - OAK STREET	148599	14999		07/01/2019	N	O	N
15.04	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - ALBION	148601	14999		08/09/2019	N	O	N
15.05	Hospital-Based Health Clinic - RHC		WABASH GENERAL HOSPITAL - GRAYVILLE	148613	14999		07/27/2020	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)						01/01/2021	12/31/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/27/2022 9:54 am

		1.00	2.00	3.00				
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr		
					1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0		35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)				N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.				N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.				N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				N	N	N	48.00
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:54 am		
			V 1.00	XVIII 2.00	XIX 3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	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	61.00
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	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N				63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:54 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00	
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00	
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N		112.00	
						1.00	2.00
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0		118.00	
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			0	0	118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1327		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:54 am	
				1.00			2.00		
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	
				1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:			Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:			PO Box:				142.00	
143.00	City:			State:		Zip Code:		143.00	
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
								4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N		N		N	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
				Name		County		State	
				0		1.00		2.00	
						Zip Code		CBSA	
						3.00		4.00	
								FTE/Campus	
								5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:54 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 9:54 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
					4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/08/2022	Y	03/08/2022
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	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: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/27/2022 9:54 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1327

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	47,520.00	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	47,520.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	47,520.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.05 RURAL HEALTH CLINIC VI	88.05				0	26.05
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: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,366	50	1,980		1.00
2.00	HMO and other (see instructions)	170	90			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	316	0	316		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	116		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,682	50	2,412		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,682	50	2,412	0.00	320.05
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC	261	0	2,645	0.00	1.52
26.01	RURAL HEALTH CLINIC II	2,029	0	8,924	0.00	19.35
26.02	RURAL HEALTH CLINIC III	3,735	0	6,129	0.00	6.73
26.03	RURAL HEALTH CLINIC IV	2,909	0	7,174	0.00	8.82
26.04	RURAL HEALTH CLINIC V	922	0	3,087	0.00	6.93
26.05	RURAL HEALTH CLINIC VI	1,678	0	3,661	0.00	8.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	371.44
28.00	Observation Bed Days		0	259		27.00
29.00	Ambulance Trips	916				28.00
30.00	Employee discount days (see instruction)			0		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	407	16	623	1.00
2.00 HMO and other (see instructions)			45	28		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	407	16	623	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
26.05 RURAL HEALTH CLINIC VI	0.00					26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1327 Component CCN: 14-8501		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	1418 COLLEGE DRIVE				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	MT.CARMEIL		IL 62863	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		
4.00	Source of Federal Funds					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
9.01	OTHER (SPECIFY)					9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
					1.00	
					2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					11.00
	CLINIC	10:00	22:00	15:00	21:00	15:00
					1.00	
					2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N				0 13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8501

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

RHC I

Cost

		County					
		4.00					
2.00	City, State, ZIP Code, County	WABASH				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	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
Facility hours of operations (1)							
11.00	CLINIC	15:00	21:00	10:00	22:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8	
Component CCN: 14-8568		Date/Time Prepared: 5/27/2022 9:54 am			
RHC II		Cost			
		1.00			
Clinic Address and Identification					
1.00	Street		1123 CHESTNUT STREET		1.00
	City	State	ZIP Code		
	1.00	2.00	3.00		
2.00	City, State, ZIP Code, County		MOUNT CARMEL IL 62863-1212		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
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?		Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		WABASH		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		18:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

From 01/01/2021

Worksheet S-8

Component CCN: 14-8568

To 12/31/2021

Date/Time Prepared:

5/27/2022 9:54 am

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8579		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1418 COLLEGE DR				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MOUNT CARMEL IL 62863				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	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WABASH				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		11.00	

Health Financial Systems		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327	Period: From 01/01/2021	Worksheet S-8
			Component CCN: 14-8579	To 12/31/2021	Date/Time Prepared: 5/27/2022 9:54 am
			RHC III		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8599		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am	
				RHC IV		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1106 OAK STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MOUNT CARMEL IL 62863				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?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WABASH				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		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327	Period: From 01/01/2021	Worksheet S-8	
			Component CCN: 14-8599	To 12/31/2021	Date/Time Prepared: 5/27/2022 9:54 am	
			RHC IV		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	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8601		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am		
				RHC V		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				26 EAST ELM STREET			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				ALBION IL 62806			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?				Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		Total Visits		
				1.00		2.00		3.00 4.00 5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County		4.00				
2.00	City, State, ZIP Code, County				EDWARDS				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	
				09:00		18:00		11.00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327 Component CCN: 14-8601	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC V		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	07:00	16:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327 Component CCN: 14-8613		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am	
		RHC VI		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1418 COLLEGE DRIVE		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		MOUNT CARMEL IL 62863		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)		CLINIC		
	10:00	22:00	15:00	21:00	15:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N		0 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
	Y/N	V	XVIII	XIX	Total Visits
	1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
			County		
			4.00		
2.00	City, State, ZIP Code, County		WABASH		
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	Facility hours of operations (1)		CLINIC		
	21:00	18:00	21:00	18:00	21:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8613		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 9:54 am	
						RHC VI		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			15:00	21:00	10:00	22:00	11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/27/2022 9:54 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.388263	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			7,870,994	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			23,688,231	6.00
7.00	Medicaid cost (line 1 times line 6)			9,197,264	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,326,270	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,326,270	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)	120,616	0	120,616	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	46,831	0	46,831	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)	46,831	0	46,831	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)			2,936,447	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			368,655	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			567,162	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,369,285	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,118,413	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,165,244	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,491,514	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,339,859	1,339,859	0	1,339,859 1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,108,555	1,108,555	648,599	1,757,154 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	361,611	6,853,122	7,214,733	0	7,214,733 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,689,804	6,202,839	8,892,643	-142,354	8,750,289 5.00
7.00	00700	OPERATION OF PLANT	299,096	1,293,665	1,592,761	-1,692	1,591,069 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	131,243	131,243 8.00
9.00	00900	HOUSEKEEPING	348,401	57,652	406,053	0	406,053 9.00
10.00	01000	DIETARY	410,139	215,328	625,467	-450,236	175,231 10.00
11.00	01100	CAFETERIA	0	0	0	432,789	432,789 11.00
13.00	01300	NURSING ADMINISTRATION	355,483	214	355,697	0	355,697 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638,154	59,690	697,844	-2,299	695,545 16.00
17.00	01700	SOCIAL SERVICE	159,122	9,234	168,356	0	168,356 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,239,430	143,863	1,383,293	-12,840	1,370,453 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,718,817	1,127,376	2,846,193	-39,010	2,807,183 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,104,668	4,081,122	5,185,790	-5,284,422	-98,632 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	956,536	1,139,077	2,095,613	-128,928	1,966,685 54.00
60.00	06000	LABORATORY	972,656	1,614,843	2,587,499	-18,122	2,569,377 60.00
65.00	06500	RESPIRATORY THERAPY	831,962	264,236	1,096,198	-20,267	1,075,931 65.00
66.00	06600	PHYSICAL THERAPY	1,148,765	281,968	1,430,733	-11,899	1,418,834 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,580	147,841	406,421	905,497	1,311,918 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,795,172	4,795,172 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	503,897	3,045,030	3,548,927	-226,361	3,322,566 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	86,421	184,833	271,254	39,005	310,259 88.00
88.01	08802	RURAL HEALTH CLINIC II	1,545,120	516,940	2,062,060	-203	2,061,857 88.01
88.02	08801	RURAL HEALTH CLINIC III	844,564	41,789	886,353	0	886,353 88.02
88.03	08803	RURAL HEALTH CLINIC IV	941,604	75,589	1,017,193	-22,046	995,147 88.03
88.04	08804	RURAL HEALTH CLINIC V	500,694	49,629	550,323	0	550,323 88.04
88.05	08805	RURAL HEALTH CLINIC VI	472,587	65,016	537,603	-16,756	520,847 88.05
90.00	09000	CLINIC	411,357	318,507	729,864	-4,152	725,712 90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,376,365	323,639	3,700,004	-258,973	3,441,031 90.01
90.02	09002	SURGICAL CLINIC	708,329	252,738	961,067	-5,793	955,274 90.02
90.03	09003	OP CLINIC	0	0	0	0	0 90.03
90.04	09004	MENTAL HEALTH CLINIC	151,733	109,136	260,869	0	260,869 90.04
90.05	09005	ENT CLINIC	9,520	178,632	188,152	-4,303	183,849 90.05
91.00	09100	EMERGENCY	1,106,332	1,349,503	2,455,835	-7,574	2,448,261 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,022,164	151,729	1,173,893	-32,739	1,141,154 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		261,336	261,336	-261,336	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,173,911	32,864,530	58,038,441	0	58,038,441 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,437	130,901	192,338	0	192,338 192.00
192.01	19201	OUTREACH	807,769	73,698	881,467	0	881,467 192.01
192.02	19202	CLINIC	0	0	0	0	0 192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	26,043,117	33,069,129	59,112,246	0	59,112,246 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	1,339,859	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-207,252	1,549,902	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-221,114	6,993,619	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-348,486	8,401,803	5.00
7.00	00700	OPERATION OF PLANT	0	1,591,069	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,243	8.00
9.00	00900	HOUSEKEEPING	0	406,053	9.00
10.00	01000	DIETARY	0	175,231	10.00
11.00	01100	CAFETERIA	-102,338	330,451	11.00
13.00	01300	NURSING ADMINISTRATION	0	355,697	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,960	683,585	16.00
17.00	01700	SOCIAL SERVICE	0	168,356	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,239,430	131,023	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-978,875	1,828,308	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	-98,632	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,966,685	54.00
60.00	06000	LABORATORY	-53,721	2,515,656	60.00
65.00	06500	RESPIRATORY THERAPY	-68,642	1,007,289	65.00
66.00	06600	PHYSICAL THERAPY	0	1,418,834	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,287	1,310,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,795,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,209	3,321,357	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	310,259	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,061,857	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	886,353	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	995,147	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	550,323	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	520,847	88.05
90.00	09000	CLINIC	-250,000	475,712	90.00
90.01	09001	ORTHOPAEDIC CLINIC	-2,970,969	470,062	90.01
90.02	09002	SURGICAL CLINIC	-708,874	246,400	90.02
90.03	09003	OP CLINIC	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	-102,990	157,879	90.04
90.05	09005	ENT CLINIC	0	183,849	90.05
91.00	09100	EMERGENCY	0	2,448,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	1,141,154	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,267,147	50,771,294	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192,338	192.00
192.01	19201	OUTREACH	0	881,467	192.01
192.02	19202	CLINIC	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,267,147	51,845,099	200.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
5/27/2022 9:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	259,056		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS			259,056		
	B - CAFE					
1.00	CAFETERIA	11.00	291,937	140,852		1.00
	TOTALS		291,937	140,852		
	C - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	261,336		1.00
	TOTALS		0	261,336		
	D - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,824		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	15,824		
	E - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	4,856		1.00
	TOTALS		0	4,856		
	F - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,795,172		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	4,795,172		
	G - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	131,243		1.00
	TOTALS		0	131,243		
	H - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	128,207		1.00
	TOTALS		0	128,207		
	I - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,020,916		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	TOTALS		0	1,020,916		
	J - RHC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	39,005	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		39,005	0		
500.00	Grand Total: Increases		330,942	6,757,462		500.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
5/27/2022 9:54 am

	Decreases						5/27/2022 9:54 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,147	10		1.00
2.00	OPERATION OF PLANT	7.00	0	6,548	0		2.00
3.00	DIETARY	10.00	0	17,447	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,299	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,299	0		5.00
6.00	OPERATING ROOM	50.00	0	14,003	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	128,713	0		7.00
8.00	LABORATORY	60.00	0	17,928	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,964	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	11,899	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	524	0		11.00
12.00	CLINIC	90.00	0	441	0		12.00
13.00	ORTHOPAEDIC CLINIC	90.01	0	6,773	0		13.00
14.00	EMERGENCY	91.00	0	2,820	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	31,251	0		15.00
	TOTALS		0	259,056			
	B - CAFE						
1.00	DIETARY	10.00	291,937	140,852	0		1.00
	TOTALS		291,937	140,852			
	C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	261,336	9		1.00
	TOTALS		0	261,336			
	D - OXYGEN						
1.00	OPERATING ROOM	50.00	0	468	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	14,402	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	954	0		3.00
	TOTALS		0	15,824			
	E - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	4,856	0		1.00
	TOTALS		0	4,856			
	F - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	4,566,680	0		1.00
2.00	ORTHOPAEDIC CLINIC	90.01	0	228,492	0		2.00
	TOTALS		0	4,795,172			
	G - LINEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	131,243	0		1.00
	TOTALS		0	131,243			
	H - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	128,207	9		1.00
	TOTALS		0	128,207			
	I - MEDICAL SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	12,840	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	36,711	0		2.00
3.00	OPERATING ROOM	50.00	0	703,271	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	215	0		4.00
5.00	LABORATORY	60.00	0	194	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	3,901	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	225,837	0		7.00
8.00	CLINIC	90.00	0	3,711	0		8.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	23,708	0		9.00
10.00	SURGICAL CLINIC	90.02	0	937	0		10.00
11.00	ENT CLINIC	90.05	0	4,303	0		11.00
12.00	EMERGENCY	91.00	0	4,754	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	534	0		13.00
	TOTALS		0	1,020,916			
	J - RHC RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	203	0	0		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	22,046	0	0		2.00
3.00	RURAL HEALTH CLINIC VI	88.05	16,756	0	0		3.00
	TOTALS		39,005	0			
500.00	Grand Total: Decreases		330,942	6,757,462			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/27/2022 9:54 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	562,437	100	0	100	0	1.00
2.00	Land Improvements	2,281,999	0	0	0	237,327	2.00
3.00	Buildings and Fixtures	28,958,345	10,361,853	0	10,361,853	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,281,793	0	0	0	929,964	5.00
6.00	Movable Equipment	17,781,408	0	0	0	9,219,587	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,865,982	10,361,953	0	10,361,953	10,386,878	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,865,982	10,361,953	0	10,361,953	10,386,878	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	562,537	0				1.00
2.00	Land Improvements	2,044,672	0				2.00
3.00	Buildings and Fixtures	39,320,198	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,351,829	0				5.00
6.00	Movable Equipment	8,561,821	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	54,841,057	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	54,841,057	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,339,859	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,108,555	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,448,414	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,339,859				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,108,555				2.00
3.00	Total (sum of lines 1-2)	0	2,448,414				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	46,279,236	0	46,279,236	0.843879	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,561,821	0	8,561,821	0.156121	0	2.00
3.00	Total (sum of lines 1-2)	54,841,057	0	54,841,057	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,339,859	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,290,846	259,056	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,630,705	259,056	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,339,859	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,549,902	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,889,761	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-223,241	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	B	-39,208	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-5,134,071			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-102,338	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,287	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,209	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-11,960	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	A&G OTHER REVENUE	B	-180,554	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN RECRUITMENT	A	-112,516	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PUBLIC RELATIONS	A	0		0.00	0	33.02
33.03	LOBBYING DUES	A	-16,208	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CRNA SALARY	A	-1,239,430	NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	CRNA EMP BEN	A	-221,114	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,267,147				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: 14-1327

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2022 9:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	978,875	978,875	0	0	0	1.00
2.00	60.00	LABORATORY	53,721	53,721	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	68,642	68,642	0	0	0	3.00
4.00	90.00	CLINIC	250,000	250,000	0	0	0	4.00
5.00	90.01	ORTHOPAEDIC CLINIC	3,021,894	2,970,969	50,925	0	0	5.00
6.00	90.02	SURGICAL CLINIC	708,874	708,874	0	0	0	6.00
7.00	90.04	MENTAL HEALTH CLINIC	102,990	102,990	0	0	0	7.00
8.00	91.00	EMERGENCY	1,185,519	0	1,185,519	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,370,515	5,134,071	1,236,444		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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	5.00
6.00	90.02	SURGICAL CLINIC	0	0	0	0	0	6.00
7.00	90.04	MENTAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	978,875		1.00
2.00	60.00	LABORATORY	0	0	0	53,721		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	68,642		3.00
4.00	90.00	CLINIC	0	0	0	250,000		4.00
5.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	2,970,969		5.00
6.00	90.02	SURGICAL CLINIC	0	0	0	708,874		6.00
7.00	90.04	MENTAL HEALTH CLINIC	0	0	0	102,990		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,134,071		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,339,859	1,339,859			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,549,902	1,549,902			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,993,619	5,867	6,786	7,006,272	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,401,803	80,115	92,674	733,816	5.00
7.00	00700	OPERATION OF PLANT	1,591,069	47,556	55,011	81,598	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,243	0	0	0	8.00
9.00	00900	HOUSEKEEPING	406,053	4,659	5,390	95,049	9.00
10.00	01000	DIETARY	175,231	36,388	42,093	32,247	10.00
11.00	01100	CAFETERIA	330,451	14,638	16,933	79,645	11.00
13.00	01300	NURSING ADMINISTRATION	355,697	2,754	3,186	96,981	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	683,585	16,091	18,613	174,097	16.00
17.00	01700	SOCIAL SERVICE	168,356	3,358	3,884	43,411	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	131,023	0	0	338,134	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,828,308	163,908	189,603	468,917	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	-98,632	233,157	269,706	301,369	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,966,685	49,763	57,564	260,956	54.00
60.00	06000	LABORATORY	2,515,656	35,483	41,045	265,354	60.00
65.00	06500	RESPIRATORY THERAPY	1,007,289	15,582	18,024	226,971	65.00
66.00	06600	PHYSICAL THERAPY	1,418,834	76,964	89,030	313,399	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,310,631	44,349	51,301	70,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,795,172	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,321,357	10,469	12,111	137,470	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	310,259	17,619	20,381	34,218	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,061,857	0	0	421,475	88.01
88.02	08801	RURAL HEALTH CLINIC III	886,353	75,455	87,284	230,409	88.02
88.03	08803	RURAL HEALTH CLINIC IV	995,147	0	0	250,868	88.03
88.04	08804	RURAL HEALTH CLINIC V	550,323	0	0	136,596	88.04
88.05	08805	RURAL HEALTH CLINIC VI	520,847	90,546	104,741	124,357	88.05
90.00	09000	CLINIC	475,712	38,312	44,318	112,224	90.00
90.01	09001	ORTHOPAEDIC CLINIC	470,062	146,213	169,135	921,117	90.01
90.02	09002	SURGICAL CLINIC	246,400	0	0	193,242	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	157,879	15,431	17,850	41,395	90.04
90.05	09005	ENT CLINIC	183,849	0	0	2,597	90.05
91.00	09100	EMERGENCY	2,448,261	42,179	48,792	301,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,141,154	67,306	77,857	278,861	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,771,294	1,334,162	1,543,312	6,769,140	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192,338	5,697	6,590	16,761	192.00
192.01	19201	OUTREACH	881,467	0	0	220,371	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
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)	51,845,099	1,339,859	1,549,902	7,006,272	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,308,408					5.00
7.00	00700	OPERATION OF PLANT	388,478	2,163,712				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,720	0	159,963			8.00
9.00	00900	HOUSEKEEPING	111,856	9,858	35	632,900		9.00
10.00	01000	DIETARY	62,577	76,986	1,053	22,622	449,197	10.00
11.00	01100	CAFETERIA	96,651	30,970	0	9,100	0	11.00
13.00	01300	NURSING ADMINISTRATION	100,360	5,827	0	1,712	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,283	34,043	0	10,003	0	16.00
17.00	01700	SOCIAL SERVICE	47,926	7,104	0	2,087	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	102,667	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	580,066	346,777	59,666	101,899	449,197	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	154,408	493,286	37,703	144,951	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	510,966	105,282	18,821	30,937	0	54.00
60.00	06000	LABORATORY	625,321	75,070	504	22,059	0	60.00
65.00	06500	RESPIRATORY THERAPY	277,450	32,966	3,681	9,687	0	65.00
66.00	06600	PHYSICAL THERAPY	415,393	162,832	11,556	47,847	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	323,177	93,828	0	27,571	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,049,355	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761,843	22,150	0	6,509	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	83,698	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	543,433	0	398	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	279,996	0	398	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	272,668	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	150,320	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	183,926	0	0	0	0	88.05
90.00	09000	CLINIC	146,741	81,057	1,115	23,818	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	373,443	309,341	0	90,898	0	90.01
90.02	09002	SURGICAL CLINIC	96,208	0	133	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	50,890	32,646	0	9,593	0	90.04
90.05	09005	ENT CLINIC	40,800	0	0	0	0	90.05
91.00	09100	EMERGENCY	621,714	89,238	23,121	26,222	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	342,511	142,398	1,779	41,843	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,018,845	2,151,659	159,963	629,358	449,197	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	48,446	12,053	0	3,542	0	192.00
192.01	19201	OUTREACH	241,117	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,308,408	2,163,712	159,963	632,900	449,197	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	578,388					11.00
13.00	01300	NURSING ADMINISTRATION	8,584	575,101				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,695	0	1,171,410			16.00
17.00	01700	SOCIAL SERVICE	6,096	0	0	282,222		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	571,824	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	86,960	245,787	436,165	282,222	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,942	200,509	229,297	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	571,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,023	0	9,969	0	0	54.00
60.00	06000	LABORATORY	42,538	0	12,462	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	31,439	0	7,477	0	0	65.00
66.00	06600	PHYSICAL THERAPY	48,279	0	69,786	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,134	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,145	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	194,404	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	29,908	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	49,847	0	0	88.05
90.00	09000	CLINIC	15,829	0	39,878	0	0	90.00
90.01	09001	ORTHOPEAEDIC CLINIC	73,375	0	84,740	0	0	90.01
90.02	09002	SURGICAL CLINIC	12,029	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	8,147	0	0	0	0	90.04
90.05	09005	ENT CLINIC	601	0	0	0	0	90.05
91.00	09100	EMERGENCY	45,572	128,805	4,985	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	578,388	575,101	1,168,918	282,222	571,824	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	2,492	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
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)	578,388	575,101	1,171,410	282,222	571,824	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,239,475	0	5,239,475	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,036,696	0	2,036,696	50.00
53.00	05300	ANESTHESIOLOGY	571,824	0	571,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069,966	0	3,069,966	54.00
60.00	06000	LABORATORY	3,635,492	0	3,635,492	60.00
65.00	06500	RESPIRATORY THERAPY	1,630,566	0	1,630,566	65.00
66.00	06600	PHYSICAL THERAPY	2,653,920	0	2,653,920	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,935,535	0	1,935,535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,844,527	0	5,844,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,287,054	0	4,287,054	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	466,175	0	466,175	88.00
88.01	08802	RURAL HEALTH CLINIC II	3,221,567	0	3,221,567	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,559,895	0	1,559,895	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,518,683	0	1,518,683	88.03
88.04	08804	RURAL HEALTH CLINIC V	867,147	0	867,147	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,074,264	0	1,074,264	88.05
90.00	09000	CLINIC	979,004	0	979,004	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,638,324	0	2,638,324	90.01
90.02	09002	SURGICAL CLINIC	548,012	0	548,012	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	333,831	0	333,831	90.04
90.05	09005	ENT CLINIC	227,847	0	227,847	90.05
91.00	09100	EMERGENCY	3,780,712	0	3,780,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,093,709	0	2,093,709	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,214,225	0	50,214,225	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	287,919	0	287,919	192.00
192.01	19201	OUTREACH	1,342,955	0	1,342,955	192.01
192.02	19202	CLINIC	0	0	0	192.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,845,099	0	51,845,099	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,867	6,786	12,653	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	80,115	92,674	172,789	5.00
7.00	00700	OPERATION OF PLANT	0	47,556	55,011	102,567	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,659	5,390	10,049	9.00
10.00	01000	DIETARY	0	36,388	42,093	78,481	10.00
11.00	01100	CAFETERIA	0	14,638	16,933	31,571	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,754	3,186	5,940	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,091	18,613	34,704	16.00
17.00	01700	SOCIAL SERVICE	0	3,358	3,884	7,242	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	163,908	189,603	353,511	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	233,157	269,706	502,863	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,763	57,564	107,327	54.00
60.00	06000	LABORATORY	0	35,483	41,045	76,528	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,582	18,024	33,606	65.00
66.00	06600	PHYSICAL THERAPY	0	76,964	89,030	165,994	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,349	51,301	95,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,469	12,111	22,580	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	17,619	20,381	38,000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	75,455	87,284	162,739	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	90,546	104,741	195,287	88.05
90.00	09000	CLINIC	0	38,312	44,318	82,630	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	146,213	169,135	315,348	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	15,431	17,850	33,281	90.04
90.05	09005	ENT CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	42,179	48,792	90,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	67,306	77,857	145,163	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,334,162	1,543,312	2,877,474	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,697	6,590	12,287	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
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	1,339,859	1,549,902	2,889,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	174,115					5.00
7.00	00700	OPERATION OF PLANT	7,266	109,980				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	537		537			8.00
9.00	00900	HOUSEKEEPING	2,092	501	0	12,814		9.00
10.00	01000	DIETARY	1,170	3,913	4	458	84,084	10.00
11.00	01100	CAFETERIA	1,808	1,574	0	184	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,877	296	0	35	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,653	1,730	0	203	0	16.00
17.00	01700	SOCIAL SERVICE	896	361	0	42	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,920	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,849	17,626	200	2,063	84,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,888	25,074	127	2,935	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,557	5,351	63	626	0	54.00
60.00	06000	LABORATORY	11,696	3,816	2	447	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,189	1,676	12	196	0	65.00
66.00	06600	PHYSICAL THERAPY	7,769	8,277	39	969	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,045	4,769	0	558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,642	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,249	1,126	0	132	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,565	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	10,164	0	1	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	5,237	0	1	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,100	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,812	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,440	0	0	0	0	88.05
90.00	09000	CLINIC	2,745	4,120	4	482	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	6,985	15,724	0	1,840	0	90.01
90.02	09002	SURGICAL CLINIC	1,799	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	952	1,659	0	194	0	90.04
90.05	09005	ENT CLINIC	763	0	0	0	0	90.05
91.00	09100	EMERGENCY	11,628	4,536	78	531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	6,406	7,238	6	847	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,699	109,367	537	12,742	84,084	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	906	613	0	72	0	192.00
192.01	19201	OUTREACH	4,510	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
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)	174,115	109,980	537	12,814	84,084	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	35,281				11.00
13.00	01300	NURSING ADMINISTRATION	524	8,847			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,421	0	43,026		16.00
17.00	01700	SOCIAL SERVICE	372	0	0	8,991	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,303	3,781	16,019	8,991	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,327	3,085	8,422	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,600	0	366	0	54.00
60.00	06000	LABORATORY	2,595	0	458	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,918	0	275	0	65.00
66.00	06600	PHYSICAL THERAPY	2,945	0	2,563	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	924	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	7,140	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	1,099	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	1,831	0	88.05
90.00	09000	CLINIC	966	0	1,465	0	90.00
90.01	09001	ORTHOPEAEDIC CLINIC	4,476	0	3,113	0	90.01
90.02	09002	SURGICAL CLINIC	734	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	497	0	0	0	90.04
90.05	09005	ENT CLINIC	37	0	0	0	90.05
91.00	09100	EMERGENCY	2,780	1,981	183	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,281	8,847	42,934	8,991	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	92	0	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
200.00		Cross Foot Adjustments					2,531
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	35,281	8,847	43,026	8,991	2,531

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	503,274	0	503,274
31.00	03100	INTENSIVE CARE UNIT	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	550,266	0	550,266
53.00	05300	ANESTHESIOLOGY	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,362	0	127,362
60.00	06000	LABORATORY	96,022	0	96,022
65.00	06500	RESPIRATORY THERAPY	43,282	0	43,282
66.00	06600	PHYSICAL THERAPY	189,122	0	189,122
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,011	0	108,011
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,642	0	19,642
73.00	07300	DRUGS CHARGED TO PATIENTS	39,259	0	39,259
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	39,627	0	39,627
88.01	08802	RURAL HEALTH CLINIC II	18,067	0	18,067
88.02	08801	RURAL HEALTH CLINIC III	168,393	0	168,393
88.03	08803	RURAL HEALTH CLINIC IV	5,553	0	5,553
88.04	08804	RURAL HEALTH CLINIC V	4,158	0	4,158
88.05	08805	RURAL HEALTH CLINIC VI	200,783	0	200,783
90.00	09000	CLINIC	92,615	0	92,615
90.01	09001	ORTHOPAEDIC CLINIC	349,144	0	349,144
90.02	09002	SURGICAL CLINIC	2,882	0	2,882
90.03	09003	OP CLINIC	0	0	0
90.04	09004	MENTAL HEALTH CLINIC	36,658	0	36,658
90.05	09005	ENT CLINIC	805	0	805
91.00	09100	EMERGENCY	113,233	0	113,233
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	160,164	0	160,164
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,868,322	0	2,868,322
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,000	0	14,000
192.01	19201	OUTREACH	4,908	0	4,908
192.02	19202	CLINIC	0	0	0
200.00		Cross Foot Adjustments	2,531	0	2,531
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	2,889,761	0	2,889,761

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1327

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	71,028					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		71,028				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	25,681,506			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,247	4,247	2,689,804	-9,308,408	42,536,691	5.00
7.00	00700	OPERATION OF PLANT	2,521	2,521	299,096	0	1,775,234	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	131,243	8.00
9.00	00900	HOUSEKEEPING	247	247	348,401	0	511,151	9.00
10.00	01000	DIETARY	1,929	1,929	118,202	0	285,959	10.00
11.00	01100	CAFETERIA	776	776	291,937	0	441,667	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	355,483	0	458,618	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	638,154	0	892,386	16.00
17.00	01700	SOCIAL SERVICE	178	178	159,122	0	219,009	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,239,430	0	469,157	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,689	8,689	1,718,817	0	2,650,736	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,360	12,360	1,104,668	0	705,600	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	956,536	0	2,334,968	54.00
60.00	06000	LABORATORY	1,881	1,881	972,656	0	2,857,538	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	831,962	0	1,267,866	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	1,148,765	0	1,898,227	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	2,351	258,580	0	1,476,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,795,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	503,897	0	3,481,407	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	934	934	125,426	0	382,477	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	1,544,917	0	2,483,332	88.01
88.02	08801	RURAL HEALTH CLINIC III	4,000	4,000	844,564	0	1,279,501	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	919,558	0	1,246,015	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	500,694	0	686,919	88.04
88.05	08805	RURAL HEALTH CLINIC VI	4,800	4,800	455,831	0	840,491	88.05
90.00	09000	CLINIC	2,031	2,031	411,357	0	670,566	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	7,751	3,376,365	0	1,706,527	90.01
90.02	09002	SURGICAL CLINIC	0	0	708,329	0	439,642	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	818	818	151,733	0	232,555	90.04
90.05	09005	ENT CLINIC	0	0	9,520	0	186,446	90.05
91.00	09100	EMERGENCY	2,236	2,236	1,106,332	0	2,841,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,568	3,568	1,022,164	0	1,565,178	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,726	70,726	24,812,300	-9,308,408	41,213,467	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	302	302	61,437	0	221,386	192.00
192.01	19201	OUTREACH	0	0	807,769	0	1,101,838	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
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)	1,339,859	1,549,902	7,006,272		9,308,408	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.863814	21.821000	0.272814		0.218832	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,653		174,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000493		0.004093	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	54,215				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,078			8.00
9.00	00900	HOUSEKEEPING	247	4	53,968		9.00
10.00	01000	DIETARY	1,929	119	1,929	100	10.00
11.00	01100	CAFETERIA	776	0	776	0	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	146	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	853	0	16.00
17.00	01700	SOCIAL SERVICE	178	0	178	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,689	6,743	8,689	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,360	4,261	12,360	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,127	2,638	0	54.00
60.00	06000	LABORATORY	1,881	57	1,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	826	416	826	0	65.00
66.00	06600	PHYSICAL THERAPY	4,080	1,306	4,080	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	0	2,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	555	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	45	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	45	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	88.05
90.00	09000	CLINIC	2,031	126	2,031	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	0	7,751	0	90.01
90.02	09002	SURGICAL CLINIC	0	15	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	818	0	818	0	90.04
90.05	09005	ENT CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,236	2,613	2,236	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,568	201	3,568	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,913	18,078	53,666	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	0	302	0	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,163,712	159,963	632,900	449,197	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.909840	8.848490	11.727320	4,491.970000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	109,980	537	12,814	84,084	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.028590	0.029705	0.237437	840.840000	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	16.00	17.00	19.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,443				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	470			16.00
17.00	01700	SOCIAL SERVICE	0	0	1,980		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,181	175	1,980	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,595	92	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4	0	0	54.00
60.00	06000	LABORATORY	0	5	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	78	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	12	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	20	0	0	88.05
90.00	09000	CLINIC	0	16	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	34	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	0	90.04
90.05	09005	ENT CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	1,667	2	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,443	469	1,980	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
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)	575,101	1,171,410	282,222	571,824	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	77.267365	2,492.361702	142.536364	5,718.240000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,847	43,026	8,991	2,531	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.188634	91.544681	4.540909	25.310000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/27/2022 9:54 am

			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	5,239,475		5,239,475	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,036,696		2,036,696	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	571,824		571,824	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069,966		3,069,966	0	0	54.00	
60.00	06000	LABORATORY	3,635,492		3,635,492	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1,630,566	0	1,630,566	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,653,920	0	2,653,920	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,935,535		1,935,535	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,844,527		5,844,527	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,287,054		4,287,054	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	466,175		466,175	0	0	88.00	
88.01	08802	RURAL HEALTH CLINIC II	3,221,567		3,221,567	0	0	88.01	
88.02	08801	RURAL HEALTH CLINIC III	1,559,895		1,559,895	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	1,518,683		1,518,683	0	0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	867,147		867,147	0	0	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	1,074,264		1,074,264	0	0	88.05	
90.00	09000	CLINIC	979,004		979,004	0	0	90.00	
90.01	09001	ORTHOPAEDIC CLINIC	2,638,324		2,638,324	0	0	90.01	
90.02	09002	SURGICAL CLINIC	548,012		548,012	0	0	90.02	
90.03	09003	OP CLINIC	0		0	0	0	90.03	
90.04	09004	MENTAL HEALTH CLINIC	333,831		333,831	0	0	90.04	
90.05	09005	ENT CLINIC	227,847		227,847	0	0	90.05	
91.00	09100	EMERGENCY	3,780,712		3,780,712	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	529,243		529,243	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,093,709		2,093,709	0	0	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	50,743,468	0	50,743,468	0	0	200.00	
201.00		Less Observation Beds	529,243		529,243			201.00	
202.00		Total (see instructions)	50,214,225	0	50,214,225	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/27/2022 9:54 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,388,596		3,388,596		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,671,479	14,737,838	22,409,317	0.090886	0.000000
53.00	05300	ANESTHESIOLOGY	1,086,728	3,167,122	4,253,850	0.134425	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,255	20,617,373	21,376,628	0.143613	0.000000
60.00	06000	LABORATORY	1,249,608	16,595,296	17,844,904	0.203727	0.000000
65.00	06500	RESPIRATORY THERAPY	401,948	2,911,743	3,313,691	0.492069	0.000000
66.00	06600	PHYSICAL THERAPY	1,174,413	6,038,722	7,213,135	0.367929	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,848,626	2,458,174	4,306,800	0.449414	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,849,873	6,782,439	14,632,312	0.399426	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,944,141	9,261,787	11,205,928	0.382570	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	364,243	364,243		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,947,080	1,947,080		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,010,453	1,010,453		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,059,340	1,059,340		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	850,201	850,201		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	646,260	646,260		88.05
90.00	09000	CLINIC	1,000	994,378	995,378	0.983550	0.000000
90.01	09001	ORTHOPAEDIC CLINIC	13,687	2,342,834	2,356,521	1.119584	0.000000
90.02	09002	SURGICAL CLINIC	2,824	362,018	364,842	1.502053	0.000000
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000
90.04	09004	MENTAL HEALTH CLINIC	0	392,414	392,414	0.850711	0.000000
90.05	09005	ENT CLINIC	0	122,500	122,500	1.859976	0.000000
91.00	09100	EMERGENCY	89,541	6,007,619	6,097,160	0.620078	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,122	331,677	337,799	1.566739	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,841,231	2,841,231	0.736902	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	27,487,841	101,842,742	129,330,583		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	27,487,841	101,842,742	129,330,583		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000			90.01
90.02	09002	SURGICAL CLINIC	0.000000			90.02
90.03	09003	OP CLINIC	0.000000			90.03
90.04	09004	MENTAL HEALTH CLINIC	0.000000			90.04
90.05	09005	ENT CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,239,475		5,239,475	0	5,239,475	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,036,696		2,036,696	0	2,036,696	50.00
53.00	05300	ANESTHESIOLOGY	571,824		571,824	0	571,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069,966		3,069,966	0	3,069,966	54.00
60.00	06000	LABORATORY	3,635,492		3,635,492	0	3,635,492	60.00
65.00	06500	RESPIRATORY THERAPY	1,630,566	0	1,630,566	0	1,630,566	65.00
66.00	06600	PHYSICAL THERAPY	2,653,920	0	2,653,920	0	2,653,920	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,935,535		1,935,535	0	1,935,535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,844,527		5,844,527	0	5,844,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,287,054		4,287,054	0	4,287,054	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	466,175		466,175	0	466,175	88.00
88.01	08802	RURAL HEALTH CLINIC II	3,221,567		3,221,567	0	3,221,567	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,559,895		1,559,895	0	1,559,895	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,518,683		1,518,683	0	1,518,683	88.03
88.04	08804	RURAL HEALTH CLINIC V	867,147		867,147	0	867,147	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,074,264		1,074,264	0	1,074,264	88.05
90.00	09000	CLINIC	979,004		979,004	0	979,004	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,638,324		2,638,324	0	2,638,324	90.01
90.02	09002	SURGICAL CLINIC	548,012		548,012	0	548,012	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	333,831		333,831	0	333,831	90.04
90.05	09005	ENT CLINIC	227,847		227,847	0	227,847	90.05
91.00	09100	EMERGENCY	3,780,712		3,780,712	0	3,780,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	529,243		529,243	0	529,243	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,093,709		2,093,709	0	2,093,709	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,743,468	0	50,743,468	0	50,743,468	200.00
201.00		Less Observation Beds	529,243		529,243		529,243	201.00
202.00		Total (see instructions)	50,214,225	0	50,214,225	0	50,214,225	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/27/2022 9:54 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,388,596		3,388,596		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,671,479	14,737,838	22,409,317	0.090886	50.00
53.00	05300	ANESTHESIOLOGY	1,086,728	3,167,122	4,253,850	0.134425	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,255	20,617,373	21,376,628	0.143613	54.00
60.00	06000	LABORATORY	1,249,608	16,595,296	17,844,904	0.203727	60.00
65.00	06500	RESPIRATORY THERAPY	401,948	2,911,743	3,313,691	0.492069	65.00
66.00	06600	PHYSICAL THERAPY	1,174,413	6,038,722	7,213,135	0.367929	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,848,626	2,458,174	4,306,800	0.449414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,849,873	6,782,439	14,632,312	0.399426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,944,141	9,261,787	11,205,928	0.382570	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	364,243	364,243	1.279846	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,947,080	1,947,080	1.654563	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,010,453	1,010,453	1.543758	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,059,340	1,059,340	1.433612	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	850,201	850,201	1.019932	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	646,260	646,260	1.662278	88.05
90.00	09000	CLINIC	1,000	994,378	995,378	0.983550	90.00
90.01	09001	ORTHOPAEDIC CLINIC	13,687	2,342,834	2,356,521	1.119584	90.01
90.02	09002	SURGICAL CLINIC	2,824	362,018	364,842	1.502053	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	392,414	392,414	0.850711	90.04
90.05	09005	ENT CLINIC	0	122,500	122,500	1.859976	90.05
91.00	09100	EMERGENCY	89,541	6,007,619	6,097,160	0.620078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,122	331,677	337,799	1.566739	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,841,231	2,841,231	0.736902	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	27,487,841	101,842,742	129,330,583		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	27,487,841	101,842,742	129,330,583		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000			88.05
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000			90.01
90.02	09002	SURGICAL CLINIC	0.000000			90.02
90.03	09003	OP CLINIC	0.000000			90.03
90.04	09004	MENTAL HEALTH CLINIC	0.000000			90.04
90.05	09005	ENT CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, 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	550,266	22,409,317	0.024555	4,353,375	106,897	50.00
53.00	05300	ANESTHESIOLOGY	0	4,253,850	0.000000	595,744	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,362	21,376,628	0.005958	507,468	3,023	54.00
60.00	06000	LABORATORY	96,022	17,844,904	0.005381	806,403	4,339	60.00
65.00	06500	RESPIRATORY THERAPY	43,282	3,313,691	0.013062	240,977	3,148	65.00
66.00	06600	PHYSICAL THERAPY	189,122	7,213,135	0.026219	628,614	16,482	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,011	4,306,800	0.025079	1,027,305	25,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,642	14,632,312	0.001342	4,504,995	6,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,259	11,205,928	0.003503	1,048,903	3,674	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	39,627	364,243	0.108793	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	18,067	1,947,080	0.009279	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	168,393	1,010,453	0.166651	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,553	1,059,340	0.005242	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,158	850,201	0.004891	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	200,783	646,260	0.310685	0	0	88.05
90.00	09000	CLINIC	92,615	995,378	0.093045	735	68	90.00
90.01	09001	ORTHOPAEDIC CLINIC	349,144	2,356,521	0.148161	0	0	90.01
90.02	09002	SURGICAL CLINIC	2,882	364,842	0.007899	874	7	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	36,658	392,414	0.093417	0	0	90.04
90.05	09005	ENT CLINIC	805	122,500	0.006571	0	0	90.05
91.00	09100	EMERGENCY	113,233	6,097,160	0.018571	1,746	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	50,836	337,799	0.150492	5,605	844	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,255,720	123,100,756		13,722,744	170,324	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1327

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			Title XVIII			Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	571,824	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	0	0	0	90.04
90.05	09005	ENT CLINIC	0	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	571,824	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	22,409,317	0.000000
53.00	05300	ANESTHESIOLOGY	0	571,824	0	4,253,850	0.134425
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,376,628	0.000000
60.00	06000	LABORATORY	0	0	0	17,844,904	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,313,691	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	7,213,135	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,306,800	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,632,312	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,205,928	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	364,243	0.000000
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	1,947,080	0.000000
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	1,010,453	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,059,340	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	850,201	0.000000
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	646,260	0.000000
90.00	09000	CLINIC	0	0	0	995,378	0.000000
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	2,356,521	0.000000
90.02	09002	SURGICAL CLINIC	0	0	0	364,842	0.000000
90.03	09003	OP CLINIC	0	0	0	0	0.000000
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	392,414	0.000000
90.05	09005	ENT CLINIC	0	0	0	122,500	0.000000
91.00	09100	EMERGENCY	0	0	0	6,097,160	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	337,799	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	571,824	0	123,100,756	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	4,353,375	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	595,744	80,083	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	507,468	0	0	0
60.00	06000	LABORATORY	0.000000	806,403	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	240,977	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	628,614	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,027,305	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	4,504,995	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,048,903	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08802	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
88.02	08801	RURAL HEALTH CLINIC III	0.000000	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	735	0	0	0
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	0	0
90.02	09002	SURGICAL CLINIC	0.000000	874	0	0	0
90.03	09003	OP CLINIC	0.000000	0	0	0	0
90.04	09004	MENTAL HEALTH CLINIC	0.000000	0	0	0	0
90.05	09005	ENT CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	1,746	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,605	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)		13,722,744	80,083	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/27/2022 9:54 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.090886	0	4,867,910	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.134425	0	892,480	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143613	0	7,970,490	0	0	54.00
60.00	06000	LABORATORY	0.203727	0	6,576,256	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.492069	0	981,673	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.367929	0	2,099,971	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.449414	0	739,407	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399426	0	2,651,403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382570	0	5,242,920	903	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.983550	0	521,606	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.119584	0	899,411	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.502053	0	140,469	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0.850711	0	325,133	0	0	90.04
90.05	09005	ENT CLINIC	1.859976	0	30,725	0	0	90.05
91.00	09100	EMERGENCY	0.620078	0	2,184,597	25,138	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.566739	0	168,800	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.736902		0			95.00
200.00		Subtotal (see instructions)		0	36,293,251	26,041	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	36,293,251	26,041	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/27/2022 9:54 am

			Title XVIII	Hospital	Cost
	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	442,425	0	50.00
53.00	05300	ANESTHESIOLOGY	119,972	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,666	0	54.00
60.00	06000	LABORATORY	1,339,761	0	60.00
65.00	06500	RESPIRATORY THERAPY	483,051	0	65.00
66.00	06600	PHYSICAL THERAPY	772,640	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	332,300	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,059,039	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,005,784	345	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08802	RURAL HEALTH CLINIC II			88.01
88.02	08801	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
90.00	09000	CLINIC	513,026	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,006,966	0	90.01
90.02	09002	SURGICAL CLINIC	210,992	0	90.02
90.03	09003	OP CLINIC	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	276,594	0	90.04
90.05	09005	ENT CLINIC	57,148	0	90.05
91.00	09100	EMERGENCY	1,354,621	15,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	264,466	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	11,383,451	15,933	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	11,383,451	15,933	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/27/2022 9:54 am

			Title XIX		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.090886	0	98,204	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.134425	0	31,871	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143613	0	375,211	0	0	54.00
60.00	06000	LABORATORY	0.203727	0	313,688	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.492069	0	14,946	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.367929	0	52,251	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.449414	0	24,546	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399426	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382570	0	30,758	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.983550	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.119584	0	14,437	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.502053	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0.850711	0	12,182	0	0	90.04
90.05	09005	ENT CLINIC	1.859976	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.620078	0	144,901	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.566739	0	11,674	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.736902	0	0			95.00
200.00		Subtotal (see instructions)		0	1,124,669	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	1,124,669	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/27/2022 9:54 am

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
			ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	8,925	0		50.00
53.00	05300	ANESTHESIOLOGY	4,284	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,885	0		54.00
60.00	06000	LABORATORY	63,907	0		60.00
65.00	06500	RESPIRATORY THERAPY	7,354	0		65.00
66.00	06600	PHYSICAL THERAPY	19,225	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,031	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,767	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	16,163	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
90.04	09004	MENTAL HEALTH CLINIC	10,363	0		90.04
90.05	09005	ENT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	89,850	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,290	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	315,044	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	315,044	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:54 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,671	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,239	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)		1,980	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		316	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		116	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,366	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)		316	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,239,475	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)		18,557	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)		664,275	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,575,200	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)		4,575,200	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,043.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,791,298	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,791,298	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,737,048	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,528,346	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)					645,718	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					645,718	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)					259	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,043.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					529,243	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	503,274	5,239,475	0.096054	529,243	50,836
91.00	Nursing Program cost	0	5,239,475	0.000000	529,243	0
92.00	Allied health cost	0	5,239,475	0.000000	529,243	0
93.00	All other Medical Education	0	5,239,475	0.000000	529,243	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:54 am	
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		2,224,565		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.090886	4,353,375	395,661	50.00
53.00	05300	ANESTHESIOLOGY	0.134425	595,744	80,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143613	507,468	72,879	54.00
60.00	06000	LABORATORY	0.203727	806,403	164,286	60.00
65.00	06500	RESPIRATORY THERAPY	0.492069	240,977	118,577	65.00
66.00	06600	PHYSICAL THERAPY	0.367929	628,614	231,285	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.449414	1,027,305	461,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399426	4,504,995	1,799,412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382570	1,048,903	401,279	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.983550	735	723	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.119584	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.502053	874	1,313	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0.850711	0	0	90.04
90.05	09005	ENT CLINIC	1.859976	0	0	90.05
91.00	09100	EMERGENCY	0.620078	1,746	1,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.566739	5,605	8,782	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,722,744	3,737,048	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)		13,722,744		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3
			Component CCN: 14-Z327		Date/Time Prepared: 5/27/2022 9:54 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.090886	209	19 50.00
53.00	05300	ANESTHESIOLOGY	0.134425	5,590	751 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143613	26,337	3,782 54.00
60.00	06000	LABORATORY	0.203727	72,549	14,780 60.00
65.00	06500	RESPIRATORY THERAPY	0.492069	37,008	18,210 65.00
66.00	06600	PHYSICAL THERAPY	0.367929	240,340	88,428 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.449414	77,135	34,666 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399426	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382570	130,642	49,980 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0 88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0 88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0 88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0 88.05
90.00	09000	CLINIC	0.983550	0	0 90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.119584	0	0 90.01
90.02	09002	SURGICAL CLINIC	1.502053	0	0 90.02
90.03	09003	OP CLINIC	0.000000	0	0 90.03
90.04	09004	MENTAL HEALTH CLINIC	0.850711	0	0 90.04
90.05	09005	ENT CLINIC	1.859976	0	0 90.05
91.00	09100	EMERGENCY	0.620078	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.566739	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		589,810	210,616 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		589,810	210,616 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:54 am	
			Title XIX	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		73,537		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.090886	202,519	18,406	50.00
53.00	05300	ANESTHESIOLOGY	0.134425	38,410	5,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143613	19,092	2,742	54.00
60.00	06000	LABORATORY	0.203727	37,822	7,705	60.00
65.00	06500	RESPIRATORY THERAPY	0.492069	6,020	2,962	65.00
66.00	06600	PHYSICAL THERAPY	0.367929	16,288	5,993	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.449414	226,475	101,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.399426	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382570	41,235	15,775	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.279846	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	1.654563	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1.543758	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.433612	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.019932	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.662278	0	0	88.05
90.00	09000	CLINIC	0.983550	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.119584	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.502053	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0.850711	0	0	90.04
90.05	09005	ENT CLINIC	1.859976	0	0	90.05
91.00	09100	EMERGENCY	0.620078	4,072	2,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.566739	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		591,933	163,052	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)		591,933		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 9:54 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,399,384	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs 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)		11,399,384	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)		11,513,378	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)		99,287	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		5,964,441	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)		5,449,650	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)		5,449,650	30.00
31.00	Primary payer payments		1,096	31.00
32.00	Subtotal (line 30 minus line 31)		5,448,554	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)		505,849	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		328,802	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		381,532	36.00
37.00	Subtotal (see instructions)		5,777,356	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)		5,777,356	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		6,478,444	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)		-701,088	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		177,047	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: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,223,497		5,946,917	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		47,737		280,502	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	07/06/2021	274,960	07/06/2021	251,025	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		274,960		251,025	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)		6,546,194		6,478,444	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		424,812		701,088	6.02
7.00	Total Medicare program liability (see instructions)		6,121,382		5,777,356	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: 14-1327

Period:

Worksheet E-1

Component CCN: 14-Z327

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:

5/27/2022 9:54 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		650,212		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		650,212		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		211,717		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		861,929		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: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part II
Date/Time Prepared:
5/27/2022 9:54 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1327

Period:

Worksheet E-2

Component CCN:14-Z327

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

Date/Time Prepared:

5/27/2022 9:54 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		652,175	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)		212,722	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		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)		864,897	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		864,897	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)		864,897	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		2,968	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		861,929	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		861,929	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		650,212	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)		211,717	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
Comparison 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:14-1327	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/27/2022 9:54 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		6,528,346	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)		6,528,346	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		6,593,629	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)		6,593,629	19.00
20.00	Deductibles (exclude professional component)		510,040	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		6,083,589	22.00
23.00	Coinsurance		1,113	23.00
24.00	Subtotal (line 22 minus line 23)		6,082,476	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		59,856	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		38,906	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,193	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		6,121,382	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		6,121,382	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		6,546,194	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-424,812	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		20,950	34.00

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

Provider CCN: 14-1327

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

Worksheet G

Date/Time Prepared:
5/27/2022 9:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	10,379,241	0	0	0	1.00
2.00	Temporary investments	19,051,238	0	0	0	2.00
3.00	Notes receivable	11,029	0	0	0	3.00
4.00	Accounts receivable	22,061,427	0	0	0	4.00
5.00	Other receivable	361,935	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,222,593	0	0	0	6.00
7.00	Inventory	1,292,071	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,769,717	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)	44,704,065	0	0	0	11.00
FIXED ASSETS						
12.00	Land	562,537	0	0	0	12.00
13.00	Land improvements	2,044,672	0	0	0	13.00
14.00	Accumulated depreciation	-1,077,034	0	0	0	14.00
15.00	Buildings	39,320,198	0	0	0	15.00
16.00	Accumulated depreciation	-13,577,981	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-2,347,483	0	0	0	18.00
19.00	Fixed equipment	4,351,829	0	0	0	19.00
20.00	Accumulated depreciation	-4,275,272	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	8,561,821	0	0	0	23.00
24.00	Accumulated depreciation	1,497,124	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,060,411	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	79,764,476	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,412,768	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,136,940	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,879,592	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,155,453	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,584,753	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,030,000	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)	3,030,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,614,753	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	57,149,723				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	57,149,723	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	79,764,476	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1327

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

Worksheet G-1

Date/Time Prepared:
5/27/2022 9:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		43,625,959		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,523,764				2.00
3.00	Total (sum of line 1 and line 2)		57,149,723		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)		57,149,723		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)		57,149,723		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: 14-1327

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2022 9:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,640,474		4,640,474	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,640,474		4,640,474	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,640,474		4,640,474	17.00
18.00	Ancillary services	24,389,075	106,934,767	131,323,842	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	364,243	364,243	20.00
20.01	RURAL HEALTH CLINIC II	0	1,947,080	1,947,080	20.01
20.02	RURAL HEALTH CLINIC III	0	1,010,453	1,010,453	20.02
20.03	RURAL HEALTH CLINIC IV	0	1,059,340	1,059,340	20.03
20.04	RURAL HEALTH CLINIC V	0	850,201	850,201	20.04
20.05	RURAL HEALTH CLINIC VI	0	0	0	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,841,231	2,841,231	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	44,821	44,821	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,029,549	115,052,136	144,081,685	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,112,246		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		59,112,246		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1327

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

Worksheet G-3

Date/Time Prepared:
5/27/2022 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,081,685	1.00
2.00	Less contractual allowances and discounts on patients' accounts	78,810,679	2.00
3.00	Net patient revenues (line 1 minus line 2)	65,271,006	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	59,112,246	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,158,760	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	39,208	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	109,162	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	1,287	16.00
17.00	Revenue from sale of drugs to other than patients	456,494	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	5,793,420	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	6,399,571	25.00
26.00	Total (line 5 plus line 25)	12,558,331	26.00
27.00	NON OPERATING G/L	-965,433	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-965,433	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,523,764	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	0	0	0	9,949	9,949
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	58,391	58,391
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	68,340	68,340
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	9,104	9,104	0	9,104
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	9,104	9,104	0	9,104
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	9,104	9,104	68,340	77,444
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	0	0
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	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	282	282	0	282
30.00	Administrative Costs	86,421	175,447	261,868	-68,340	193,528
31.00	Total Facility Overhead (sum of lines 29 and 30)	86,421	175,729	262,150	-68,340	193,810
32.00	Total facility costs (sum of lines 22, 28 and 31)	86,421	184,833	271,254	0	271,254

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	39,005	39,005	2.00
3.00	Nurse Practitioner	0	9,949	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	58,391	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	39,005	107,345	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,104	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	9,104	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	39,005	116,449	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	282	29.00
30.00	Administrative Costs	0	193,528	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	193,810	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	39,005	310,259	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

						RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ions	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	669,829	669,829		1.00	
2.00	Physician Assistant	0	0	0	88,763	88,763		2.00	
3.00	Nurse Practitioner	0	0	0	97,082	97,082		3.00	
4.00	Visiting Nurse	0	0	0	0	0		4.00	
5.00	Other Nurse	0	0	0	315,680	315,680		5.00	
6.00	Clinical Psychologist	0	0	0	0	0		6.00	
7.00	Clinical Social Worker	0	0	0	0	0		7.00	
8.00	Laboratory Technician	0	0	0	0	0		8.00	
9.00	Other Facility Health Care Staff Costs	0	0	0	57,614	57,614		9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	1,228,968	1,228,968		10.00	
11.00	Physician Services Under Agreement	0	0	0	0	0		11.00	
12.00	Physician Supervision Under Agreement	0	0	0	0	0		12.00	
13.00	Other Costs Under Agreement	0	0	0	0	0		13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0		14.00	
15.00	Medical Supplies	0	47,202	47,202	0	47,202		15.00	
16.00	Transportation (Health Care Staff)	0	0	0	0	0		16.00	
17.00	Depreciation-Medical Equipment	0	0	0	0	0		17.00	
18.00	Professional Liability Insurance	0	0	0	0	0		18.00	
19.00	Other Health Care Costs	0	0	0	0	0		19.00	
20.00	Allowable GME Costs							20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	47,202	47,202	0	47,202		21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	47,202	47,202	1,228,968	1,276,170		22.00	
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0		23.00	
24.00	Dental	0	0	0	0	0		24.00	
25.00	Optometry	0	0	0	0	0		25.00	
25.01	Telehealth	0	0	0	0	0		25.01	
25.02	Chronic Care Management	0	0	0	0	0		25.02	
26.00	All other nonreimbursable costs	0	0	0	0	0		26.00	
27.00	Nonallowable GME costs							27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0		28.00	
FACILITY OVERHEAD									
29.00	Facility Costs	0	14,988	14,988	0	14,988		29.00	
30.00	Administrative Costs	1,545,120	454,750	1,999,870	-1,228,968	770,902		30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,545,120	469,738	2,014,858	-1,228,968	785,890		31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,545,120	516,940	2,062,060	0	2,062,060		32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-203	669,626	1.00
2.00	Physician Assistant	0	88,763	2.00
3.00	Nurse Practitioner	0	97,082	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	315,680	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	57,614	9.00
10.00	Subtotal (sum of lines 1 through 9)	-203	1,228,765	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	47,202	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	47,202	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-203	1,275,967	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	14,988	29.00
30.00	Administrative Costs	0	770,902	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	785,890	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-203	2,061,857	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

						RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	564,200	564,200	1.00		
2.00	Physician Assistant	0	0	0	53,083	53,083	2.00		
3.00	Nurse Practitioner	0	0	0	2,012	2,012	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	59,970	59,970	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	38,582	38,582	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	717,847	717,847	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	16,038	16,038	0	16,038	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	0	0	0	0	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	16,038	16,038	0	16,038	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	16,038	16,038	717,847	733,885	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	7,512	7,512	0	7,512	29.00		
30.00	Administrative Costs	844,564	18,239	862,803	-717,847	144,956	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	844,564	25,751	870,315	-717,847	152,468	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	844,564	41,789	886,353	0	886,353	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	564,200	1.00
2.00	Physician Assistant	0	53,083	2.00
3.00	Nurse Practitioner	0	2,012	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	59,970	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	38,582	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	717,847	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	16,038	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	16,038	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	733,885	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,512	29.00
30.00	Administrative Costs	0	144,956	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	152,468	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	886,353	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

						RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	504,733	504,733	1.00		
2.00	Physician Assistant	0	0	0	233,106	233,106	2.00		
3.00	Nurse Practitioner	0	0	0	0	0	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	137,520	137,520	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	875,359	875,359	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	16,557	16,557	0	16,557	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	0	0	0	0	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	16,557	16,557	0	16,557	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	16,557	16,557	875,359	891,916	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	9,406	9,406	0	9,406	29.00		
30.00	Administrative Costs	941,604	49,626	991,230	-875,359	115,871	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	941,604	59,032	1,000,636	-875,359	125,277	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	941,604	75,589	1,017,193	0	1,017,193	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	504,733	1.00
2.00	Physician Assistant	-22,046	211,060	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	137,520	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-22,046	853,313	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	16,557	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	16,557	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-22,046	869,870	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	9,406	29.00
30.00	Administrative Costs	0	115,871	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	125,277	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-22,046	995,147	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	132,447	132,447
2.00	Physician Assistant	0	0	0	13,815	13,815
3.00	Nurse Practitioner	0	0	0	114,964	114,964
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	151,113	151,113
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	412,339	412,339
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	11,830	11,830	0	11,830
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	11,830	11,830	0	11,830
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	11,830	11,830	412,339	424,169
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	0	0
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	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	35,312	35,312	0	35,312
30.00	Administrative Costs	500,694	2,487	503,181	-412,339	90,842
31.00	Total Facility Overhead (sum of lines 29 and 30)	500,694	37,799	538,493	-412,339	126,154
32.00	Total facility costs (sum of lines 22, 28 and 31)	500,694	49,629	550,323	0	550,323

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

RHC V

Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	132,447
2.00	Physician Assistant	0	13,815
3.00	Nurse Practitioner	0	114,964
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	151,113
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	412,339
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	11,830
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	11,830
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	424,169
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	35,312
30.00	Administrative Costs	0	90,842
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,154
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	550,323

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8613

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC VI		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	38,773	38,773
3.00	Nurse Practitioner	0	0	0	58,730	58,730
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	42,358	42,358
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	19,268	19,268
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	159,129	159,129
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	24,811	24,811	0	24,811
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	24,811	24,811	0	24,811
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	24,811	24,811	159,129	183,940
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	0	0
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	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,681	1,681	0	1,681
30.00	Administrative Costs	472,587	38,524	511,111	-159,129	351,982
31.00	Total Facility Overhead (sum of lines 29 and 30)	472,587	40,205	512,792	-159,129	353,663
32.00	Total facility costs (sum of lines 22, 28 and 31)	472,587	65,016	537,603	0	537,603

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8613

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

RHC VI

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	-16,756	22,017	2.00
3.00	Nurse Practitioner	0	58,730	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	42,358	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	19,268	9.00
10.00	Subtotal (sum of lines 1 through 9)	-16,756	142,373	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	24,811	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	24,811	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-16,756	167,184	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	1,681	29.00
30.00	Administrative Costs	0	351,982	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	353,663	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-16,756	520,847	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8501

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.41	1,285	2,100	861		2.00
3.00	Nurse Practitioner	0.44	1,359	2,100	924		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.85	2,644		1,785	2,644	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.85	2,644			2,644	8.00
9.00	Physician Services Under Agreements		1			1	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)					116,449	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					116,449	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					193,810	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					155,916	15.00
16.00	Total overhead (sum of lines 14 and 15)					349,726	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					349,726	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					349,726	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					466,175	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8568

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.82	4,339	2,352	4,281		1.00
2.00	Physician Assistant	0.92	1,791	1,932	1,777		2.00
3.00	Nurse Practitioner	0.89	1,902	1,932	1,719		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.63	8,032		7,777	8,032	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)	3.63	8,032			8,032	8.00
9.00	Physician Services Under Agreements		892			892	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)					1,275,967	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,275,967	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					785,890	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,159,710	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,945,600	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,945,600	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,945,600	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,221,567	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8579

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.90	4,416	4,200	3,780		1.00
2.00	Physician Assistant	0.45	1,655	2,100	945		2.00
3.00	Nurse Practitioner	0.02	58	2,100	42		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.37	6,129		4,767	6,129	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.37	6,129			6,129	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)					733,885	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					733,885	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					152,468	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					673,542	15.00
16.00	Total overhead (sum of lines 14 and 15)					826,010	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					826,010	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					826,010	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,559,895	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8599

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.97	2,844	2,898	2,811		1.00
2.00	Physician Assistant	0.68	2,977	1,512	1,028		2.00
3.00	Nurse Practitioner	0.88	1,353	1,512	1,331		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.53	7,174		5,170	7,174	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)	2.53	7,174			7,174	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)					869,870	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					869,870	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					125,277	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					523,536	15.00
16.00	Total overhead (sum of lines 14 and 15)					648,813	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					648,813	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					648,813	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,518,683	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8601

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		RHC V		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.35	1,080	2,940	1,029	1.00
2.00	Physician Assistant	0.12	168	1,260	151	2.00
3.00	Nurse Practitioner	0.85	1,839	1,260	1,071	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.32	3,087		2,251	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.32	3,087		3,087	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)				424,169	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				424,169	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				126,154	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				316,824	15.00
16.00	Total overhead (sum of lines 14 and 15)				442,978	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				442,978	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				442,978	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				867,147	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8613

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

Date/Time Prepared:

5/27/2022 9:54 am

				RHC VI		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.64	921	2,100	1,344		2.00
3.00	Nurse Practitioner	0.95	2,740	2,100	1,995		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	3,661		3,339	3,661	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.59	3,661			3,661	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)					167,184	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					167,184	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					353,663	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					553,417	15.00
16.00	Total overhead (sum of lines 14 and 15)					907,080	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					907,080	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					907,080	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,074,264	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			466,175	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			466,175	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,644	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			1	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,645	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			176.25	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	183.66	8.00
9.00	Rate for Program covered visits (see instructions)		176.25	176.25	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		65	196	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		11,456	34,545	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	46,001	16.00
16.01	Total program charges (see instructions)(from contractor's records)			36,652	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			33,064	16.04
16.05	Total program cost (see instructions)		0	33,064	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,671	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			6,397	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			33,064	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			33,064	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			33,064	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			28,871	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)			4,193	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1327 Component CCN:14-8568	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,221,567	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			100,448	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,121,119	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,032	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			892	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,924	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			349.74	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	354.66	8.00
9.00	Rate for Program covered visits (see instructions)		349.74	349.74	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		507	1,522	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		177,318	532,304	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	709,622	16.00
16.01	Total program charges (see instructions)(from contractor's records)			307,310	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			32,401	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			74,818	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.)			482,192	16.04
16.05	Total program cost (see instructions)		0	557,010	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			32,064	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			48,569	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			557,010	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			23,153	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			580,163	22.00
23.00	Allowable bad debts (see instructions)			284	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			185	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			580,348	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			518,438	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)			61,910	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am	
			Title XVIII	RHC III	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,559,895	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			36,163	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,523,732	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,129	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)			6,129	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			248.61	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	210.10	8.00
9.00	Rate for Program covered visits (see instructions)		248.61	210.10	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		934	2,801	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		232,202	588,490	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	820,692	16.00
16.01	Total program charges (see instructions)(from contractor's records)			552,837	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			16,437	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			24,401	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.)			590,158	16.04
16.05	Total program cost (see instructions)		0	614,559	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			58,594	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			95,560	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			614,559	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,235	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			641,794	22.00
23.00	Allowable bad debts (see instructions)			685	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			445	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			642,239	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			539,097	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)			103,142	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8599	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am		
		Title XVIII	RHC IV	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,518,683	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			32,293	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,486,390	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,174	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)			7,174	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			207.19	7.00	
			Calculation of Limit (1)			
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			87.52	183.55	8.00
9.00	Rate for Program covered visits (see instructions)			207.19	183.55	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			727	2,182	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			150,627	400,506	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	551,133	16.00
16.01	Total program charges (see instructions)(from contractor's records)				394,899	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				28,172	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				39,318	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.)				366,207	16.04
16.05	Total program cost (see instructions)			0	405,525	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				54,056	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				62,533	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				405,525	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				23,133	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				428,658	22.00
23.00	Allowable bad debts (see instructions)				142	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				92	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				32	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)				428,750	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				376,117	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)				52,633	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8601	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am	
			Title XVIII	RHC V	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			867,147	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			22,645	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			844,502	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,087	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,087	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			273.57	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	271.59	8.00
9.00	Rate for Program covered visits (see instructions)		273.57	271.59	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		230	692	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		62,921	187,940	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	250,861	16.00
16.01	Total program charges (see instructions)(from contractor's records)			141,634	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			23,290	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			41,251	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.)			156,652	16.04
16.05	Total program cost (see instructions)		0	197,903	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			13,795	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			20,910	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			197,903	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			11,034	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			208,937	22.00
23.00	Allowable bad debts (see instructions)			346	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			225	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			56	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)			209,162	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			224,380	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)			-15,218	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8613	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 9:54 am
		Title XVIII	RHC VI	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,074,264	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		34,172	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,040,092	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,661	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,661	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		284.10	7.00
		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	378.73	8.00
9.00	Rate for Program covered visits (see instructions)	284.10	284.10	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	419	1,259	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	119,038	357,682	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	476,720	16.00
16.01	Total program charges (see instructions)(from contractor's records)		265,362	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,007	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,181	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.)		347,110	16.04
16.05	Total program cost (see instructions)	0	363,291	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,652	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,941	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		363,291	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,697	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		387,988	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		387,988	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		434,578	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)		-46,590	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: 14-1327

Period:

Worksheet M-4

Component CCN: 14-8568

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,228,765	1,228,765	1,228,765	1,228,765	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001439	0.002981	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,768	3,663	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	29,606	4,748	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	31,374	8,411	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,275,967	1,275,967	1,275,967	1,275,967	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,945,600	1,945,600	1,945,600	1,945,600	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024588	0.006592	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	47,838	12,825	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	79,212	21,236	0	0	10.00
11.00	Total number of injections/infusions (from your records)	181	375	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	437.64	56.63	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	41	92	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)	17,943	5,210	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)		100,448			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)		23,153			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet M-4

Component CCN: 14-8579

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	717,847	717,847	717,847	717,847	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001163	0.007102	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	835	5,098	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,524	3,557	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,359	8,655	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	733,885	733,885	733,885	733,885	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	826,010	826,010	826,010	826,010	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011390	0.011793	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,408	9,741	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,767	18,396	0	0	10.00
11.00	Total number of injections/infusions (from your records)	46	281	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	386.24	65.47	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	40	180	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)	15,450	11,785	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)		36,163			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)		27,235			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet M-4

Component CCN: 14-8599

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	853,313	853,313	853,313	853,313	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001585	0.006638	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,353	5,664	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,669	2,811	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,022	8,475	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	869,870	869,870	869,870	869,870	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	648,813	648,813	648,813	648,813	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011521	0.009743	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,475	6,321	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,497	14,796	0	0	10.00
11.00	Total number of injections/infusions (from your records)	53	222	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	330.13	66.65	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	41	144	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)	13,535	9,598	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		32,293			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)		23,133			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet M-4

Component CCN: 14-8601

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		RHC V	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	412,339	412,339	412,339	412,339	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001048	0.002816	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	432	1,161	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,851	1,633	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,283	2,794	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	424,169	424,169	424,169	424,169	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	442,978	442,978	442,978	442,978	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019528	0.006587	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,650	2,918	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,933	5,712	0	0	10.00
11.00	Total number of injections/infusions (from your records)	48	129	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	352.77	44.28	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	24	58	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8,466	2,568	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)		22,645			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		11,034			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet M-4

Component CCN: 14-8613

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/27/2022 9:54 am

		Title XVIII		RHC VI	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)	142,373	142,373	142,373	142,373	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000295	0.003205	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	42	456	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,617	2,203	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,659	2,659	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	167,184	167,184	167,184	167,184	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	907,080	907,080	907,080	907,080	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015905	0.015905	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	14,427	14,427	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,086	17,086	0	0	10.00
11.00	Total number of injections/infusions (from your records)	16	174	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	1,067.88	98.20	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	121	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)	12,815	11,882	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)		34,172			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)		24,697			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		28,871	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		28,871		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		4,193		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		33,064		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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			414,929	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			07/06/2021	103,509	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			103,509	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			518,438	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			61,910	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			580,348	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		539,097	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		539,097		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		103,142		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		642,239		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: 14-1327 Component CCN: 14-8599	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			376,117	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			376,117	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			52,633	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			428,750	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC V	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		224,380	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		224,380		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		15,218		6.02
7.00	Total Medicare program liability (see instructions)		209,162		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: 14-1327 Component CCN: 14-8613	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 9:54 am	
			RHC VI	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		257,586	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		07/06/2021	176,992		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		176,992		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		434,578		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		46,590		6.02
7.00	Total Medicare program liability (see instructions)		387,988		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00