

State Copy

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

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: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 4:51 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/23/2021	Time: 4:51 pm
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARSHALL BROWNING HOSPITAL (14-1331) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DANIEL EAVES
 Officer or Administrator of Provider(s)

CEO
 Title

11/23/2021 04:51:20 PM
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	134,412	-327,459	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	90,850	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		175,417		0	10.00
10.01	RURAL HEALTH CLINIC II - FHC	0		16,708		0	10.01
200.00	Total	0	225,262	-135,334	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.

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 4:51 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 900 NORTH WASHINGTON STREET		PO Box:				1.00		
2.00	City: DUQUOIN		State: IL		Zip Code: 62832		County: PERRY		
		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		MARSHALL BROWNING HOSPITAL		141331	99914	1	01/01/2004	N
4.00	Subprovider - IPF								O
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MARSHALL BROWNING SWING BED		14Z331	99914		01/01/2004	N
8.00	Swing Beds - NF								O
9.00	Hospital-Based SNF								N
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		MARSHALL BROWNING PHYSICIAN CLINIC		148504	99914		05/01/2009	N
15.01	Hospital-Based Health Clinic - RHC II		MARSHALL BROWNING FAMILY HEALTH CENTE		148597	99914		06/28/2018	N
16.00	Hospital-Based Health Clinic - FQHC								O
17.00	Hospital-Based (CMHC) I								N
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)						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)					N	N	N	22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations 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)								22.04
22.04	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.								
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
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	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	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.						N	56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N	57.00
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

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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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To 06/30/2021Worksheet S-2
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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)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 4:51 pm	
				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.	Y	Y	N	N	109.00	
				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	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	411,147		0		0118.01	
				1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 4:51 pm	
		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	Y		Y		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	
						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	
						3.00	
						CBSA	
						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.			N		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)			Y		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: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 4:51 pm
			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: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 4:51 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N		Legal Oper.	
				1.00		2.00	
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			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	09/08/2021	Y	09/08/2021 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		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: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		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.	ANDREW	MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586660	AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
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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.	CPA	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: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

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	16,464.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	16,464.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	16,464.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II - FHC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	444	6	686		1.00
2.00	HMO and other (see instructions)	82	34			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	774	0	955		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	65		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,218	6	1,706		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,218	6	1,706	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	3,012	0	9,725	0.00	26.00
26.01	RURAL HEALTH CLINIC II - FHC	994	0	3,016	0.00	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		0	290		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	152	3	229	1.00
2.00 HMO and other (see instructions)			20	11		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	152	3	229	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 - FHC	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1331 Component CCN: 14-8504		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 4:51 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				900 N. WASHINGTON		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				DU QUOIN IL 62832		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						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		11.00
				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				PERRY		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				16:30 08:00		16:30 08:00		11.00

Health Financial Systems		MARSHALL BROWNING HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1331	Period: From 07/01/2020	Worksheet S-8
			Component CCN: 14-8504	To 06/30/2021	Date/Time Prepared: 11/23/2021 4:51 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1331 Component CCN: 14-8597		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 4:51 pm	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				20 N. WASHINGTON		1.00		
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				DU QUION IL 62832		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		16:30		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				PERRY				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				16:30		08:00		16:30
				08:00		16:30		08:00	
				16:30		08:00		16:30	
				11.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1331 Component CCN: 14-8597	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 11/23/2021 4:51 pm	
			RHC II		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 4:51 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.536864	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,731,955	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		8,395,523	6.00
7.00	Medicaid cost (line 1 times line 6)		4,507,254	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)		775,299	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)		775,299	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)	133,971	0	133,971 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	71,924	0	71,924 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)	71,924	0	71,924 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,578,210	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		100,978	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		155,351	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,422,859	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		818,255	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		890,179	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,665,478	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1331

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

Worksheet A

Date/Time Prepared:
11/23/2021 4:51 pm

	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	CAP REL COSTS-BLDG & FIXT		657,214	657,214	338,617	995,831	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		414,852	414,852	-25,636	389,216	2.00
3.00	00300	OTHER CAP REL COSTS		90,328	90,328	-90,328	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,609,927	2,609,927	-151,262	2,458,665	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,374,158	2,483,439	3,857,597	0	3,857,597	5.00
6.00	00600	MAINTENANCE & REPAIRS	281,089	199,088	480,177	0	480,177	6.00
7.00	00700	OPERATION OF PLANT	0	223,733	223,733	0	223,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32	42,222	42,254	0	42,254	8.00
9.00	00900	HOUSEKEEPING	344,240	45,820	390,060	0	390,060	9.00
10.00	01000	DIETARY	286,844	153,785	440,629	0	440,629	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	508,300	32,759	541,059	-147,682	393,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	352,976	1,397,928	1,750,904	0	1,750,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,673	70,488	558,161	0	558,161	16.00
17.00	01700	SOCIAL SERVICE	223,193	195,525	418,718	0	418,718	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,270,324	877,257	2,147,581	147,682	2,295,263	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	375,431	51,267	426,698	11,749	438,447	50.00
53.00	05300	ANESTHESIOLOGY	0	97,046	97,046	0	97,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	575,100	748,611	1,323,711	0	1,323,711	54.00
60.00	06000	LABORATORY	471,623	658,469	1,130,092	0	1,130,092	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	299,896	62,071	361,967	0	361,967	65.00
66.00	06600	PHYSICAL THERAPY	769,640	80,273	849,913	-189,701	660,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	107,585	107,585	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	82,116	82,116	68.00
69.00	06900	ELECTROCARDIOLOGY	9,677	6,945	16,622	0	16,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	339,015	339,015	0	339,015	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	121,177	7,062	128,239	0	128,239	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,498,953	523,747	2,022,700	140,058	2,162,758	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	492,971	35,100	528,071	65,427	593,498	88.01
90.00	09000	CLINIC	15,286	681,526	696,812	170,131	866,943	90.00
91.00	09100	EMERGENCY	702,133	1,145,647	1,847,780	56,929	1,904,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		394,253	394,253	-394,253	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,460,716	14,325,397	24,786,113	121,432	24,907,545	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	315,785	21,083	336,868	-168,435	168,433	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	97,353	77,246	174,599	47,003	221,602	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	10,873,854	14,423,726	25,297,580	0	25,297,580	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1331

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

Worksheet A

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-8,961	986,870	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-832	388,384	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,793	2,489,458	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-626,421	3,231,176	5.00
6.00	00600	MAINTENANCE & REPAIRS	-952	479,225	6.00
7.00	00700	OPERATION OF PLANT	0	223,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-333	41,921	8.00
9.00	00900	HOUSEKEEPING	-414	389,646	9.00
10.00	01000	DIETARY	-56,166	384,463	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-716	392,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-85,302	1,665,602	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,090	559,251	16.00
17.00	01700	SOCIAL SERVICE	0	418,718	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-745,640	1,549,623	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-62,118	376,329	50.00
53.00	05300	ANESTHESIOLOGY	0	97,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-838	1,322,873	54.00
60.00	06000	LABORATORY	-1,150	1,128,942	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-15,052	346,915	65.00
66.00	06600	PHYSICAL THERAPY	-761	659,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	107,585	67.00
68.00	06800	SPEECH PATHOLOGY	-1,838	80,278	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-27,352	311,663	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	-1,366	126,873	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-810	2,161,948	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	-323	593,175	88.01
90.00	09000	CLINIC	-691,158	175,785	90.00
91.00	09100	EMERGENCY	-683	1,904,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,297,303	22,610,242	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-336	168,097	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	192.01
192.02	19202	INDEPENDENT LIVING	-1,424	220,178	192.02
192.03	19203	MEALS ON WHEELS	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,299,063	22,998,517	200.00

RECLASSIFICATIONS

Provider CCN: 14-1331

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 4:51 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - TO RECLASS INTEREST EXP				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	389,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,103	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	394,253	
	F - TO RECLASS DEPRECIATION EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	82,895	1.00
2.00	RURAL HEALTH CLINIC II - FHC	88.01	0	41,702	2.00
3.00	INDEPENDENT LIVING	192.02	0	47,003	3.00
	TOTALS		0	171,600	
	G - RECLASS PT COSTS TO OT & SP				
1.00	OCCUPATIONAL THERAPY	67.00	103,185	4,400	1.00
2.00	SPEECH PATHOLOGY	68.00	82,116	0	2.00
	TOTALS		185,301	4,400	
	H - RECLASS PHYSICIAN BENEFITS				
1.00	OPERATING ROOM	50.00	0	11,749	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	57,163	2.00
3.00	RURAL HEALTH CLINIC II - FHC	88.01	0	23,725	3.00
4.00	CLINIC	90.00	0	1,696	4.00
5.00	EMERGENCY	91.00	0	56,929	5.00
	TOTALS		0	151,262	
	I - RECLASS SPECIALTY CLINIC STAFFING				
1.00	CLINIC	90.00	157,893	10,542	1.00
	TOTALS		157,893	10,542	
	J - RECLASS IP CHARGE NURSES				
1.00	ADULTS & PEDIATRICS	30.00	147,682	0	1.00
	TOTALS		147,682	0	
500.00	Grand Total: Increases		490,876	732,057	500.00

RECLASSIFICATIONS

Provider CCN: 14-1331

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 4:51 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	C - TO RECLASS INTEREST EXP					
1.00	INTEREST EXPENSE	113.00	0	394,253	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	394,253		
	F - TO RECLASS DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	112,564	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,036	9	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	171,600		
	G - RECLASS PT COSTS TO OT & SP					
1.00	PHYSICAL THERAPY	66.00	185,301	4,400	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		185,301	4,400		
	H - RECLASS PHYSICIAN BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	151,262	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		0	151,262		
	I - RECLASS SPECIALTY CLINIC STAFFING					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	157,893	10,542	0	1.00
	TOTALS		157,893	10,542		
	J - RECLASS IP CHARGE NURSES					
1.00	NURSING ADMINISTRATION	13.00	147,682	0	0	1.00
	TOTALS		147,682	0		
500.00	Grand Total: Decreases		490,876	732,057		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,114	0	0	0	0	1.00
2.00	Land Improvements	1,260,841	0	0	0	0	2.00
3.00	Buildings and Fixtures	7,674,169	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,758,661	256,266	0	256,266	4,316	5.00
6.00	Movable Equipment	5,362,276	401,958	0	401,958	75,833	6.00
7.00	HIT designated Assets	1,586,972	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,646,033	658,224	0	658,224	80,149	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,646,033	658,224	0	658,224	80,149	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,114	0				1.00
2.00	Land Improvements	1,260,841	0				2.00
3.00	Buildings and Fixtures	7,674,169	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	7,010,611	0				5.00
6.00	Movable Equipment	5,688,401	0				6.00
7.00	HIT designated Assets	1,586,972	0				7.00
8.00	Subtotal (sum of lines 1-7)	23,224,108	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	23,224,108	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	657,214	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	414,852	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,072,066	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	657,214				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	414,852				2.00
3.00	Total (sum of lines 1-2)	0	1,072,066				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,948,736	0	15,948,736	0.686732	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,275,371	0	7,275,371	0.313268	0	2.00
3.00	Total (sum of lines 1-2)	23,224,107	0	23,224,107	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	CAP REL COSTS-BLDG & FIXT	0	62,031	62,031	544,650	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,297	28,297	354,984	0	2.00
3.00	Total (sum of lines 1-2)	0	90,328	90,328	899,634	0	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	CAP REL COSTS-BLDG & FIXT	380,189	0	0	62,031	986,870	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,103	0	0	28,297	388,384	2.00
3.00	Total (sum of lines 1-2)	385,292	0	0	90,328	1,375,254	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1331

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-8,961	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-27,352	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,510,933			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	-46,566	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-84,855	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	1,090	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1331

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-832	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-5,405	ADMINISTRATIVE & GENERAL	5.00	0	33.00
36.00	IHA/AHA DUES USED FOR LOBBYING	A	-8,234	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MARKETING	A	-92,370	ADMINISTRATIVE & GENERAL	5.00	0	37.00
41.00	DEPRECIATION	A	-3,529	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00	DEPRECIATION	A	-952	MAINTENANCE & REPAIRS	6.00	0	43.00
44.00	DEPRECIATION	A	-333	LAUNDRY & LINEN SERVICE	8.00	0	44.00
45.00	DEPRECIATION	A	-414	HOUSEKEEPING	9.00	0	45.00
45.01	DEPRECIATION	A	-1,075	DIETARY	10.00	0	45.01
45.02	DEPRECIATION	A	-716	NURSING ADMINISTRATION	13.00	0	45.02
45.03	DEPRECIATION	A	-447	PHARMACY	15.00	0	45.03
45.04	DEPRECIATION	A	0	MEDICAL RECORDS & LIBRARY	16.00	0	45.04
45.05	DEPRECIATION	A	-1,640	ADULTS & PEDIATRICS	30.00	0	45.05
45.06	DEPRECIATION	A	-597	OPERATING ROOM	50.00	0	45.06
45.07	DEPRECIATION	A	-838	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08	DEPRECIATION	A	-1,150	LABORATORY	60.00	0	45.08
45.09	DEPRECIATION	A	-798	RESPIRATORY THERAPY	65.00	0	45.09
45.10	DEPRECIATION	A	-761	PHYSICAL THERAPY	66.00	0	45.10
45.11	DEPRECIATION	A	-1,366	CARDIAC REHABILITATION	73.01	0	45.11
45.12	DEPRECIATION	A	-810	RURAL HEALTH CLINIC	88.00	0	45.12
45.13	DEPRECIATION	A	-683	EMERGENCY	91.00	0	45.13
46.00	DEPRECIATION	A	-336	PHYSICIANS PRIVATE OFFICES	192.00	0	46.00
46.01	DEPRECIATION	A	-1,424	INDEPENDENT LIVING	192.02	0	46.01
46.02	DEPRECIATION	A	-323	RURAL HEALTH CLINIC II - FHC	88.01	0	46.02
47.00	PROVIDER TAX ASSESSMENT	A	-516,883	ADMINISTRATIVE & GENERAL	5.00	0	47.00
47.01	DIABETES EDUCATION	B	-8,525	DIETARY	10.00	0	47.01
47.02	CONTRACTED THERAPY EXPENSES	A	-1,838	SPEECH PATHOLOGY	68.00	0	47.02
47.03	POST RETIREMENT BENEFITS PAID	B	30,793	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,299,063				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: 14-1331

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

Worksheet A-8-2

Date/Time Prepared:
11/23/2021 4:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	744,000	744,000	0	0	0	1.00
2.00	91.00	EMERGENCY	1,114,320	0	1,114,320	0	0	2.00
3.00	60.00	LABORATORY	24,187	0	24,187	0	0	3.00
4.00	50.00	OPERATING ROOM	61,521	61,521	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	14,254	14,254	0	0	0	5.00
6.00	90.00	CLINIC	691,158	691,158	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,649,440	1,510,933	1,138,507		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	744,000		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	61,521		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	14,254		5.00
6.00	90.00	CLINIC	0	0	0	691,158		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,510,933		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 4:51 pm		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						114	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						23.90	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	722.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	87.05	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.53	43.53	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						62,850	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						62,850	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						62,850	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						87.05	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						67,899	22.00
23.00	Total salary equivalency (see instructions)						67,899	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						4,962	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						4,962	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						2,725	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						7,687	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						7,687	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 4:51 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.05	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						67,899	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						7,687	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						75,586	63.00
64.00	Total cost of outside supplier services (from your records)						47,705	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						4,962	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,725	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						7,687	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,725	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,725	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 4:51 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					15	1.00
2.00	Line 1 multiplied by 15 hours per week					225	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					28	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					22.66	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	80.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.52	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.26	41.26	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					6,602	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					6,602	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					6,602	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					82.53	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					18,569	22.00
23.00	Total salary equivalency (see instructions)					18,569	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,155	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,155	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					634	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,789	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,789	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 4:51 pm		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.52	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						18,569	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,789	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						20,358	63.00
64.00	Total cost of outside supplier services (from your records)						4,400	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,155	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						634	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,789	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						634	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						634	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	986,870	986,870			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	388,384		388,384		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,489,458	0	0	2,489,458	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,231,176	255,453	101,601	353,469	3,941,699
6.00	00600	MAINTENANCE & REPAIRS	479,225	0	0	72,303	551,528
7.00	00700	OPERATION OF PLANT	223,733	87,679	34,873	0	346,285
8.00	00800	LAUNDRY & LINEN SERVICE	41,921	33,405	13,286	8	88,620
9.00	00900	HOUSEKEEPING	389,646	19,052	7,578	88,547	504,823
10.00	01000	DIETARY	384,463	51,911	20,647	73,784	530,805
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	392,661	9,704	3,860	92,760	498,985
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	1,665,602	15,089	6,002	90,795	1,777,488
16.00	01600	MEDICAL RECORDS & LIBRARY	559,251	20,970	8,341	125,442	714,004
17.00	01700	SOCIAL SERVICE	418,718	2,058	818	57,411	479,005
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,549,623	154,387	61,405	364,750	2,130,165
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	376,329	70,303	27,962	80,746	555,340
53.00	05300	ANESTHESIOLOGY	97,046	0	0	0	97,046
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,322,873	21,389	8,507	147,931	1,500,700
60.00	06000	LABORATORY	1,128,942	31,170	12,397	121,314	1,293,823
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	346,915	32,529	12,938	77,141	469,523
66.00	06600	PHYSICAL THERAPY	659,451	43,579	17,333	150,307	870,670
67.00	06700	OCCUPATIONAL THERAPY	107,585	8,180	3,253	26,542	145,560
68.00	06800	SPEECH PATHOLOGY	80,278	1,791	712	21,122	103,903
69.00	06900	ELECTROCARDIOLOGY	16,622	953	379	2,489	20,443
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	311,663	0	0	0	311,663
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	CARDIAC REHABILITATION	126,873	8,421	3,349	31,170	169,813
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,161,948	0	0	155,012	2,316,960
88.01	08801	RURAL HEALTH CLINIC II - FHC	593,175	0	0	65,606	658,781
90.00	09000	CLINIC	175,785	34,243	13,620	44,546	268,194
91.00	09100	EMERGENCY	1,904,026	39,984	15,903	180,607	2,140,520
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,610,242	942,250	374,764	2,423,802	22,486,346
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,377	0	0	10,377
192.00	19200	PHYSICIANS PRIVATE OFFICES	168,097	34,243	13,620	40,614	256,574
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0
192.02	19202	INDEPENDENT LIVING	220,178	0	0	25,042	245,220
192.03	19203	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	22,998,517	986,870	388,384	2,489,458	22,998,517

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,941,699					5.00
6.00	00600	MAINTENANCE & REPAIRS	114,077	665,605				6.00
7.00	00700	OPERATION OF PLANT	71,625	68,398	486,308			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,330	26,059	25,236	158,245		8.00
9.00	00900	HOUSEKEEPING	104,417	14,863	14,393	0	638,496	9.00
10.00	01000	DIETARY	109,791	40,496	39,216	0	47,166	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	103,210	7,570	7,331	0	8,817	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	367,654	11,771	11,399	0	13,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,684	16,359	15,842	0	19,054	16.00
17.00	01700	SOCIAL SERVICE	99,077	1,605	1,554	0	1,870	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	440,601	120,435	116,630	158,245	140,277	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	114,866	54,843	53,110	0	63,877	50.00
53.00	05300	ANESTHESIOLOGY	20,073	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,403	16,686	16,158	0	19,434	54.00
60.00	06000	LABORATORY	267,613	24,315	23,547	0	28,321	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	97,116	25,375	24,574	0	29,556	65.00
66.00	06600	PHYSICAL THERAPY	180,089	33,996	32,921	0	39,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,107	6,381	6,179	0	7,432	67.00
68.00	06800	SPEECH PATHOLOGY	21,491	1,397	1,353	0	1,627	68.00
69.00	06900	ELECTROCARDIOLOGY	4,228	743	720	0	866	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,464	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	35,124	6,569	6,362	0	7,651	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	479,244	60,441	0	0	70,398	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	136,262	34,590	0	0	40,288	88.01
90.00	09000	CLINIC	55,473	26,713	25,869	0	31,113	90.00
91.00	09100	EMERGENCY	442,743	31,192	30,206	0	36,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,835,762	630,797	452,600	158,245	607,383	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,146	8,095	7,839	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	53,070	26,713	25,869	0	31,113	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	50,721	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,941,699	665,605	486,308	158,245	638,496	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	767,474					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	625,913		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	767,474	0	0	217,249	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	53,684	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	51,287	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	99,932	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,646	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,043	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,655	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	20,723	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	29,617	0	90.00
91.00	09100	EMERGENCY	0	0	0	120,077	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	767,474	0	0	625,913	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	767,474	0	0	625,913	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,182,022					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	912,943				16.00
17.00	01700	SOCIAL SERVICE	0	0	583,111			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	74,218	583,111	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	31,172	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	8,826	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	194,365	0	0	0	54.00
60.00	06000	LABORATORY	0	190,810	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,928	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	57,665	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,395	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,114	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,823	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	48,132	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,182,022	95,156	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	5,775	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	54,297	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	10,446	0	0	0	88.01
90.00	09000	CLINIC	0	7,529	0	0	0	90.00
91.00	09100	EMERGENCY	0	76,292	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,182,022	912,943	583,111	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	2,182,022	912,943	583,111	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,748,405	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	926,892	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	125,945	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,057,746	0	54.00
60.00	06000	LABORATORY	0	0	0	1,828,429	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	730,359	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,314,869	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	220,700	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	147,928	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	42,478	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	424,259	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,277,178	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	252,017	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,981,340	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	880,367	0	88.01
90.00	09000	CLINIC	0	0	0	444,508	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,877,360	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	22,280,780	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	28,457	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	393,339	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	295,941	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	22,998,517	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		4,748,405	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.01	07301	CARDIAC REHABILITATION	73.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		22,280,780	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	FAMILY MEDICAL CLINIC	192.01
192.02	19202	INDEPENDENT LIVING	192.02
192.03	19203	MEALS ON WHEELS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		22,998,517	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	255,453	101,601	357,054	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	87,679	34,873	122,552	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,405	13,286	46,691	8.00
9.00	00900	HOUSEKEEPING	0	19,052	7,578	26,630	9.00
10.00	01000	DIETARY	0	51,911	20,647	72,558	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	9,704	3,860	13,564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	15,089	6,002	21,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,970	8,341	29,311	16.00
17.00	01700	SOCIAL SERVICE	0	2,058	818	2,876	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	154,387	61,405	215,792	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	70,303	27,962	98,265	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,389	8,507	29,896	54.00
60.00	06000	LABORATORY	0	31,170	12,397	43,567	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,529	12,938	45,467	65.00
66.00	06600	PHYSICAL THERAPY	0	43,579	17,333	60,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,180	3,253	11,433	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,791	712	2,503	68.00
69.00	06900	ELECTROCARDIOLOGY	0	953	379	1,332	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	8,421	3,349	11,770	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	88.01
90.00	09000	CLINIC	0	34,243	13,620	47,863	90.00
91.00	09100	EMERGENCY	0	39,984	15,903	55,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	942,250	374,764	1,317,014	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,377	0	10,377	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	34,243	13,620	47,863	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	192.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	986,870	388,384	1,375,254	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	357,054					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,333	10,333				6.00
7.00	00700	OPERATION OF PLANT	6,488	1,062	130,102			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,660	405	6,751	55,507		8.00
9.00	00900	HOUSEKEEPING	9,458	231	3,851	0	40,170	9.00
10.00	01000	DIETARY	9,945	629	10,491	0	2,967	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,349	118	1,961	0	555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	33,303	183	3,050	0	863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,378	254	4,238	0	1,199	16.00
17.00	01700	SOCIAL SERVICE	8,975	25	416	0	118	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,911	1,867	31,203	55,507	8,825	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,405	851	14,208	0	4,019	50.00
53.00	05300	ANESTHESIOLOGY	1,818	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,117	259	4,323	0	1,223	54.00
60.00	06000	LABORATORY	24,241	377	6,299	0	1,782	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,797	394	6,574	0	1,859	65.00
66.00	06600	PHYSICAL THERAPY	16,313	528	8,807	0	2,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,727	99	1,653	0	468	67.00
68.00	06800	SPEECH PATHOLOGY	1,947	22	362	0	102	68.00
69.00	06900	ELECTROCARDIOLOGY	383	12	193	0	54	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,839	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	3,182	102	1,702	0	481	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	43,417	938	0	0	4,429	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	12,343	537	0	0	2,535	88.01
90.00	09000	CLINIC	5,025	415	6,921	0	1,957	90.00
91.00	09100	EMERGENCY	40,105	484	8,081	0	2,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,459	9,792	121,084	55,507	38,213	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	194	126	2,097	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,807	415	6,921	0	1,957	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	4,594	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	357,054	10,333	130,102	55,507	40,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	96,590					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	25,547		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,590	0	0	8,867	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,191	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,093	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,079	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	720	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	573	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	68	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	846	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	1,209	0	90.00
91.00	09100	EMERGENCY	0	0	0	4,901	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,590	0	0	25,547	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	96,590	0	0	25,547	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	58,490					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,380				16.00
17.00	01700	SOCIAL SERVICE	0	0	12,410			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,934	12,410			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,652	0			50.00
53.00	05300	ANESTHESIOLOGY	0	468	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,291	0			54.00
60.00	06000	LABORATORY	0	10,114	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	1,745	0			65.00
66.00	06600	PHYSICAL THERAPY	0	3,057	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	392	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	218	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	733	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,551	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,490	5,044	0			73.00
73.01	07301	CARDIAC REHABILITATION	0	306	0			73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,878	0			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	554	0			88.01
90.00	09000	CLINIC	0	399	0			90.00
91.00	09100	EMERGENCY	0	4,044	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,490	48,380	12,410	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0			192.01
192.02	19202	INDEPENDENT LIVING	0	0	0			192.02
192.03	19203	MEALS ON WHEELS	0	0	0			192.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	58,490	48,380	12,410	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
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To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
			23.00	24.00	25.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				474,906	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				131,591	0	50.00
53.00	05300	ANESTHESIOLOGY				2,286	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				74,109	0	54.00
60.00	06000	LABORATORY				86,380	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				66,929	0	65.00
66.00	06600	PHYSICAL THERAPY				96,187	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				17,492	0	67.00
68.00	06800	SPEECH PATHOLOGY				5,727	0	68.00
69.00	06900	ELECTROCARDIOLOGY				2,775	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				8,390	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				63,534	0	73.00
73.01	07301	CARDIAC REHABILITATION				18,389	0	73.01
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				51,662	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC				15,969	0	88.01
90.00	09000	CLINIC				63,789	0	90.00
91.00	09100	EMERGENCY				115,788	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,295,903	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				12,794	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES				61,963	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC				0	0	192.01
192.02	19202	INDEPENDENT LIVING				4,594	0	192.02
192.03	19203	MEALS ON WHEELS				0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,375,254	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.01	07301	CARDIAC REHABILITATION	73.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	FAMILY MEDICAL CLINIC	192.01
192.02	19202	INDEPENDENT LIVING	192.02
192.03	19203	MEALS ON WHEELS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,697					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,880				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,678,089			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,112	20,112	1,374,158	-3,941,699	19,056,818	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	281,089	0	551,528	6.00
7.00	00700	OPERATION OF PLANT	6,903	6,903	0	0	346,285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	32	0	88,620	8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	344,240	0	504,823	9.00
10.00	01000	DIETARY	4,087	4,087	286,844	0	530,805	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	360,618	0	498,985	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	352,976	0	1,777,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	487,673	0	714,004	16.00
17.00	01700	SOCIAL SERVICE	162	162	223,193	0	479,005	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	1,418,006	0	2,130,165	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,535	5,535	313,910	0	555,340	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	97,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	575,100	0	1,500,700	54.00
60.00	06000	LABORATORY	2,454	2,454	471,623	0	1,293,823	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	299,896	0	469,523	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	584,339	0	870,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	103,185	0	145,560	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	82,116	0	103,903	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	9,677	0	20,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	311,663	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	121,177	0	169,813	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	602,629	0	2,316,960	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	255,051	0	658,781	88.01
90.00	09000	CLINIC	2,696	2,696	173,179	0	268,194	90.00
91.00	09100	EMERGENCY	3,148	3,148	702,133	0	2,140,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,184	74,184	9,422,844	-3,941,699	18,544,647	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	0	0	0	10,377	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,696	2,696	157,892	0	256,574	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	97,353	0	245,220	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	986,870	388,384	2,489,458		3,941,699	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.701520	5.051821	0.257226		0.206839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		357,054	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.018736	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: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	67,176					6.00
7.00	00700	OPERATION OF PLANT	6,903	50,682				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	1,996			8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	0	55,326		9.00
10.00	01000	DIETARY	4,087	4,087	0	4,087	1,996	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	0	764	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	0	1,188	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	0	1,651	0	16.00
17.00	01700	SOCIAL SERVICE	162	162	0	162	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	1,996	12,155	1,996	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,535	5,535	0	5,535	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	0	1,684	0	54.00
60.00	06000	LABORATORY	2,454	2,454	0	2,454	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	0	2,561	0	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	0	3,431	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	0	644	0	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	0	141	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	0	75	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	0	663	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,100	0	0	6,100	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	3,491	0	0	3,491	0	88.01
90.00	09000	CLINIC	2,696	2,696	0	2,696	0	90.00
91.00	09100	EMERGENCY	3,148	3,148	0	3,148	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,663	47,169	1,996	52,630	1,996	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	817	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,696	2,696	0	2,696	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	665,605	486,308	158,245	638,496	767,474	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.908375	9.595280	79.281062	11.540614	384.506012	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,333	130,102	55,507	40,170	96,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.153820	2.567026	27.809118	0.726060	48.391784	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: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,659,936		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	1,250,901	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	1,270,324	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	313,910	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	299,896	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	584,339	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	103,185	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	82,116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9,677	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,250,901	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	121,177	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	173,179	0	90.00
91.00	09100	EMERGENCY	0	0	702,133	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3,659,936	0	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	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	192.03
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)	0	0	625,913	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.171017	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	25,547	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.006980	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,501,749					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,373,872	100	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,417,027	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	401,229	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,836,116	0	0	0	0	54.00
60.00	06000	LABORATORY	8,673,981	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,496,858	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,621,390	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,179	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	187,013	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	628,360	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,188,014	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,325,681	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	262,537	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,468,249	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	474,882	0	0	0	0	88.01
90.00	09000	CLINIC	342,240	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,468,121	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,501,749	100	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	912,943	583,111	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.021998	5,831.110000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,380	12,410	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001166	124.100000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1331

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00	00500	ADMINISTRATIVE & GENERAL			5.00	
6.00	00600	MAINTENANCE & REPAIRS			6.00	
7.00	00700	OPERATION OF PLANT			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE			8.00	
9.00	00900	HOUSEKEEPING			9.00	
10.00	01000	DIETARY			10.00	
11.00	01100	CAFETERIA			11.00	
12.00	01200	MAINTENANCE OF PERSONNEL			12.00	
13.00	01300	NURSING ADMINISTRATION			13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00	
15.00	01500	PHARMACY			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00	
17.00	01700	SOCIAL SERVICE			17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00	
20.00	02000	NURSING SCHOOL			20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
73.01	07301	CARDIAC REHABILITATION	0	0	73.01	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	88.01	
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE			113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00	
192.01	19201	FAMILY MEDICAL CLINIC	0	0	192.01	
192.02	19202	INDEPENDENT LIVING	0	0	192.02	
192.03	19203	MEALS ON WHEELS	0	0	192.03	
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)	0	0	202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

			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	4,748,405		4,748,405	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	926,892		926,892	0	0	50.00
53.00	05300	ANESTHESIOLOGY	125,945		125,945	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,746		2,057,746	0	0	54.00
60.00	06000	LABORATORY	1,828,429		1,828,429	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	730,359	0	730,359	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,314,869	0	1,314,869	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,700	0	220,700	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	147,928	0	147,928	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,478		42,478	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,259		424,259	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,277,178		2,277,178	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	252,017		252,017	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,981,340		2,981,340	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	880,367		880,367	0	0	88.01
90.00	09000	CLINIC	444,508		444,508	0	0	90.00
91.00	09100	EMERGENCY	2,877,360		2,877,360	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,663		711,663		0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,992,443	0	22,992,443	0	0	200.00
201.00		Less Observation Beds	711,663		711,663			201.00
202.00		Total (see instructions)	22,280,780	0	22,280,780	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	936,038		936,038		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,464	1,381,563	1,417,027	0.654110	0.000000
53.00	05300	ANESTHESIOLOGY	16,676	384,553	401,229	0.313898	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	230,437	8,605,679	8,836,116	0.232879	0.000000
60.00	06000	LABORATORY	851,854	7,822,127	8,673,981	0.210795	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	544,096	952,762	1,496,858	0.487928	0.000000
66.00	06600	PHYSICAL THERAPY	247,476	2,373,914	2,621,390	0.501592	0.000000
67.00	06700	OCCUPATIONAL THERAPY	93,149	243,030	336,179	0.656495	0.000000
68.00	06800	SPEECH PATHOLOGY	5,088	181,925	187,013	0.791004	0.000000
69.00	06900	ELECTROCARDIOLOGY	29,136	599,224	628,360	0.067601	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,342,059	845,955	2,188,014	0.193901	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,085,808	3,239,873	4,325,681	0.526432	0.000000
73.01	07301	CARDIAC REHABILITATION	0	262,537	262,537	0.959929	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,468,249	2,468,249		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	474,882	474,882		88.01
90.00	09000	CLINIC	0	342,240	342,240	1.298820	0.000000
91.00	09100	EMERGENCY	61,063	3,407,058	3,468,121	0.829660	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	48,260	2,389,574	2,437,834	0.291924	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,526,604	35,975,145	41,501,749		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,526,604	35,975,145	41,501,749		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301	CARDIAC REHABILITATION	0.000000			73.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC				88.01
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

			Title XIX	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,748,405		4,748,405	0	4,748,405 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	926,892		926,892	0	926,892 50.00
53.00	05300 ANESTHESIOLOGY	125,945		125,945	0	125,945 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,057,746		2,057,746	0	2,057,746 54.00
60.00	06000 LABORATORY	1,828,429		1,828,429	0	1,828,429 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	730,359	0	730,359	0	730,359 65.00
66.00	06600 PHYSICAL THERAPY	1,314,869	0	1,314,869	0	1,314,869 66.00
67.00	06700 OCCUPATIONAL THERAPY	220,700	0	220,700	0	220,700 67.00
68.00	06800 SPEECH PATHOLOGY	147,928	0	147,928	0	147,928 68.00
69.00	06900 ELECTROCARDIOLOGY	42,478		42,478	0	42,478 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	424,259		424,259	0	424,259 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,277,178		2,277,178	0	2,277,178 73.00
73.01	07301 CARDIAC REHABILITATION	252,017		252,017	0	252,017 73.01
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LITHOTRIPSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2,981,340		2,981,340	0	2,981,340 88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	880,367		880,367	0	880,367 88.01
90.00	09000 CLINIC	444,508		444,508	0	444,508 90.00
91.00	09100 EMERGENCY	2,877,360		2,877,360	0	2,877,360 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	711,663		711,663		711,663 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	22,992,443	0	22,992,443	0	22,992,443 200.00
201.00	Less Observation Beds	711,663		711,663		711,663 201.00
202.00	Total (see instructions)	22,280,780	0	22,280,780	0	22,280,780 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/23/2021 4:51 pm		
				Title XIX			Hospital		PPS	
Cost Center Description				Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
				Inpatient	Outpatient	Total (col. 6 + col. 7)				
				6.00	7.00	8.00				
				9.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		936,038		936,038				30.00
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM		35,464	1,381,563	1,417,027	0.654110	0.000000		50.00
53.00	05300	ANESTHESIOLOGY		16,676	384,553	401,229	0.313898	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		230,437	8,605,679	8,836,116	0.232879	0.000000		54.00
60.00	06000	LABORATORY		851,854	7,822,127	8,673,981	0.210795	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY		544,096	952,762	1,496,858	0.487928	0.000000		65.00
66.00	06600	PHYSICAL THERAPY		247,476	2,373,914	2,621,390	0.501592	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY		93,149	243,030	336,179	0.656495	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY		5,088	181,925	187,013	0.791004	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY		29,136	599,224	628,360	0.067601	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		1,342,059	845,955	2,188,014	0.193901	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		1,085,808	3,239,873	4,325,681	0.526432	0.000000		73.00
73.01	07301	CARDIAC REHABILITATION		0	262,537	262,537	0.959929	0.000000		73.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0.000000	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY		0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC		0	2,468,249	2,468,249	1.207877	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC		0	474,882	474,882	1.853865	0.000000		88.01
90.00	09000	CLINIC		0	342,240	342,240	1.298820	0.000000		90.00
91.00	09100	EMERGENCY		61,063	3,407,058	3,468,121	0.829660	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		48,260	2,389,574	2,437,834	0.291924	0.000000		92.00
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE								113.00
200.00		Subtotal (see instructions)		5,526,604	35,975,145	41,501,749				200.00
201.00		Less Observation Beds								201.00
202.00		Total (see instructions)		5,526,604	35,975,145	41,501,749				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.654110			50.00
53.00	05300	ANESTHESIOLOGY	0.313898			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232879			54.00
60.00	06000	LABORATORY	0.210795			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.487928			65.00
66.00	06600	PHYSICAL THERAPY	0.501592			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.656495			67.00
68.00	06800	SPEECH PATHOLOGY	0.791004			68.00
69.00	06900	ELECTROCARDIOLOGY	0.067601			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.526432			73.00
73.01	07301	CARDIAC REHABILITATION	0.959929			73.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.207877			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1.853865			88.01
90.00	09000	CLINIC	1.298820			90.00
91.00	09100	EMERGENCY	0.829660			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.291924			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	926,892	131,591	795,301	0	0	50.00
53.00	05300	ANESTHESIOLOGY	125,945	2,286	123,659	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,746	74,109	1,983,637	0	0	54.00
60.00	06000	LABORATORY	1,828,429	86,380	1,742,049	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	730,359	66,929	663,430	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,314,869	96,187	1,218,682	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,700	17,492	203,208	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	147,928	5,727	142,201	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,478	2,775	39,703	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,259	8,390	415,869	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,277,178	63,534	2,213,644	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	252,017	18,389	233,628	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,981,340	51,662	2,929,678	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	880,367	15,969	864,398	0	0	88.01
90.00	09000	CLINIC	444,508	63,789	380,719	0	0	90.00
91.00	09100	EMERGENCY	2,877,360	115,788	2,761,572	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,663	71,176	640,487	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,244,038	892,173	17,351,865	0	0	200.00
201.00		Less Observation Beds	711,663	71,176	640,487	0	0	201.00
202.00		Total (line 200 minus line 201)	17,532,375	820,997	16,711,378	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	926,892	1,417,027	0.654110	50.00
53.00	05300	ANESTHESIOLOGY	125,945	401,229	0.313898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,057,746	8,836,116	0.232879	54.00
60.00	06000	LABORATORY	1,828,429	8,673,981	0.210795	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	730,359	1,496,858	0.487928	65.00
66.00	06600	PHYSICAL THERAPY	1,314,869	2,621,390	0.501592	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,700	336,179	0.656495	67.00
68.00	06800	SPEECH PATHOLOGY	147,928	187,013	0.791004	68.00
69.00	06900	ELECTROCARDIOLOGY	42,478	628,360	0.067601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,259	2,188,014	0.193901	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,277,178	4,325,681	0.526432	73.00
73.01	07301	CARDIAC REHABILITATION	252,017	262,537	0.959929	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,981,340	2,468,249	1.207877	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	880,367	474,882	1.853865	88.01
90.00	09000	CLINIC	444,508	342,240	1.298820	90.00
91.00	09100	EMERGENCY	2,877,360	3,468,121	0.829660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,663	2,437,834	0.291924	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,244,038	40,565,711		200.00
201.00		Less Observation Beds	711,663	0		201.00
202.00		Total (line 200 minus line 201)	17,532,375	40,565,711		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part II Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	131,591	1,417,027	0.092864	15,799	1,467	50.00	
53.00	05300	ANESTHESIOLOGY	2,286	401,229	0.005697	6,822	39	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,109	8,836,116	0.008387	179,170	1,503	54.00	
60.00	06000	LABORATORY	86,380	8,673,981	0.009959	308,305	3,070	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	66,929	1,496,858	0.044713	198,528	8,877	65.00	
66.00	06600	PHYSICAL THERAPY	96,187	2,621,390	0.036693	21,772	799	66.00	
67.00	06700	OCCUPATIONAL THERAPY	17,492	336,179	0.052032	2,917	152	67.00	
68.00	06800	SPEECH PATHOLOGY	5,727	187,013	0.030624	3,072	94	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,775	628,360	0.004416	13,282	59	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,390	2,188,014	0.003835	220,384	845	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	63,534	4,325,681	0.014688	351,599	5,164	73.00	
73.01	07301	CARDIAC REHABILITATION	18,389	262,537	0.070043	0	0	73.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	51,662	2,468,249	0.020931	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II - FHC	15,969	474,882	0.033627	0	0	88.01	
90.00	09000	CLINIC	63,789	342,240	0.186387	0	0	90.00	
91.00	09100	EMERGENCY	115,788	3,468,121	0.033386	60,002	2,003	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,176	2,437,834	0.029196	47,380	1,383	92.00	
200.00		Total (lines 50 through 199)	892,173	40,565,711		1,429,032	25,455	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION		0	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC		0	0	0	0	0	88.01
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 4:51 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,417,027	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	401,229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,836,116	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,673,981	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,496,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,621,390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	336,179	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	187,013	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	628,360	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,188,014	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,325,681	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	262,537	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,468,249	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	474,882	0.000000	88.01
90.00	09000	CLINIC	0	0	0	342,240	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,468,121	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,437,834	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	40,565,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 4:51 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	15,799	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,822	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	179,170	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	308,305	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	198,528	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	21,772	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,917	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,072	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,282	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	220,384	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	351,599	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	60,002	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	47,380	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,429,032	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 4:51 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.654110	0	421,800	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.313898	0	121,635	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232879	0	3,278,538	0	0	0	54.00
60.00	06000	LABORATORY	0.210795	0	2,985,708	92	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.487928	0	230,288	152	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.501592	0	807,749	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.656495	0	39,387	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.791004	0	20,997	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067601	0	229,778	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901	0	151,450	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.526432	0	1,913,069	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.959929	0	174,466	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC							88.01
90.00	09000	CLINIC	1.298820	0	144,105	0	0	0	90.00
91.00	09100	EMERGENCY	0.829660	0	1,017,864	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.291924	0	670,222	0	0	0	92.00
200.00		Subtotal (see instructions)		0	12,207,056	244	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	12,207,056	244	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	275,904	0					50.00
53.00	05300	ANESTHESIOLOGY	38,181	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	763,503	0					54.00
60.00	06000	LABORATORY	629,372	19					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	112,364	74					65.00
66.00	06600	PHYSICAL THERAPY	405,160	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	25,857	0					67.00
68.00	06800	SPEECH PATHOLOGY	16,609	0					68.00
69.00	06900	ELECTROCARDIOLOGY	15,533	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,366	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,007,101	0					73.00
73.01	07301	CARDIAC REHABILITATION	167,475	0					73.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC							88.01
90.00	09000	CLINIC	187,166	0					90.00
91.00	09100	EMERGENCY	844,481	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	195,654	0					92.00
200.00		Subtotal (see instructions)	4,713,726	93					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	4,713,726	93					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331

Period:

Worksheet D

Component CCN: 14-Z331

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/23/2021 4:51 pm

				Title XVIII		Swing Beds - SNF		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	0.654110	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.313898	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.232879	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.210795	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.487928	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.501592	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.656495	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.791004	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.067601	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.526432	0	0	0	0	73.00	
73.01	07301	CARDIAC REHABILITATION	0.959929	0	0	0	0	73.01	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
88.01	08801	RURAL HEALTH CLINIC II - FHC						88.01	
90.00	09000	CLINIC	1.298820	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.829660	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.291924	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1331

Period:

Worksheet D

Component CCN:14-Z331

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/23/2021 4:51 pm

			Title XVIII		Swing Beds - SNF	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	CARDIAC REHABILITATION	0	0		73.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC				88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		474,906	235,355	239,551	976	245.44	30.00
200.00	Total (lines 30 through 199)		474,906		239,551	976		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		6	1,473				
200.00	Total (lines 30 through 199)		6	1,473				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	131,591	1,417,027	0.092864	0	50.00
53.00	05300	ANESTHESIOLOGY	2,286	401,229	0.005697	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,109	8,836,116	0.008387	0	54.00
60.00	06000	LABORATORY	86,380	8,673,981	0.009959	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	66,929	1,496,858	0.044713	0	65.00
66.00	06600	PHYSICAL THERAPY	96,187	2,621,390	0.036693	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,492	336,179	0.052032	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,727	187,013	0.030624	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,775	628,360	0.004416	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,390	2,188,014	0.003835	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,534	4,325,681	0.014688	0	73.00
73.01	07301	CARDIAC REHABILITATION	18,389	262,537	0.070043	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	51,662	2,468,249	0.020931	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	15,969	474,882	0.033627	0	88.01
90.00	09000	CLINIC	63,789	342,240	0.186387	0	90.00
91.00	09100	EMERGENCY	115,788	3,468,121	0.033386	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,176	2,437,834	0.029196	0	92.00
200.00		Total (lines 50 through 199)	892,173	40,565,711		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/23/2021 4:51 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	976	0.00	6	30.00	
200.00		Total (lines 30 through 199)		0	0	976		6	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 CARDIAC REHABILITATION	0	0	0	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	1,417,027	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	401,229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	8,836,116	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	8,673,981	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,496,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,621,390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	336,179	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	187,013	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	628,360	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	2,188,014	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	4,325,681	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION		0	0	0	262,537	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	2,468,249	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC		0	0	0	474,882	0.000000	88.01
90.00	09000	CLINIC		0	0	0	342,240	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	3,468,121	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,437,834	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	40,565,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0	0	0	0 73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0	0	0	0 88.01
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 4:51 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		976	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)		686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		445	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)		510	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		40	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)		25	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		444	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)		342	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)		432	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		147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		151.95	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,748,405	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)		5,901	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)		3,799	25.00
26.00	Total swing-bed cost (see instructions)		2,353,289	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,395,116	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,395,116	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)		2,454.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,089,585	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,089,585	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					523,658	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,613,243	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)					839,275	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,060,137	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,899,412	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)					290	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,454.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					711,663	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	474,906	4,748,405	0.100014	711,663	71,176	90.00		
91.00	Nursing School cost	0	4,748,405	0.000000	711,663	0	91.00		
92.00	Allied health cost	0	4,748,405	0.000000	711,663	0	92.00		
93.00	All other Medical Education	0	4,748,405	0.000000	711,663	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 4:51 pm	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			976	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)			686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			445	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)			510	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			40	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)			25	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			6	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,748,405	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)			5,901	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)			3,688	25.00
26.00	Total swing-bed cost (see instructions)			2,353,226	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,395,179	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,395,179	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)			2,454.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			14,724	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)			14,724	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,724 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)					1,473 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)					1,473 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,251 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					290 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,454.08 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					711,683 89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1331		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 4:51 pm	
				Title XIX		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	474,906	4,748,405	0.100014	711,683	71,178			90.00
91.00	Nursing School cost	0	4,748,405	0.000000	711,683	0			91.00
92.00	Allied health cost	0	4,748,405	0.000000	711,683	0			92.00
93.00	All other Medical Education	0	4,748,405	0.000000	711,683	0			93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 4:51 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		424,062		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.654110	15,799	10,334	50.00
53.00	05300 ANESTHESIOLOGY	0.313898	6,822	2,141	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232879	179,170	41,725	54.00
60.00	06000 LABORATORY	0.210795	308,305	64,989	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487928	198,528	96,867	65.00
66.00	06600 PHYSICAL THERAPY	0.501592	21,772	10,921	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.656495	2,917	1,915	67.00
68.00	06800 SPEECH PATHOLOGY	0.791004	3,072	2,430	68.00
69.00	06900 ELECTROCARDIOLOGY	0.067601	13,282	898	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901	220,384	42,733	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.526432	351,599	185,093	73.00
73.01	07301 CARDIAC REHABILITATION	0.959929	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000 CLINIC	1.298820	0	0	90.00
91.00	09100 EMERGENCY	0.829660	60,002	49,781	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.291924	47,380	13,831	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,429,032	523,658	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)		1,429,032		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331 Component CCN: 14-Z331	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 4:51 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.654110	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.313898	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232879	50,145	11,678	54.00
60.00	06000 LABORATORY	0.210795	267,346	56,355	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487928	344,608	168,144	65.00
66.00	06600 PHYSICAL THERAPY	0.501592	164,610	82,567	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.656495	68,871	45,213	67.00
68.00	06800 SPEECH PATHOLOGY	0.791004	864	683	68.00
69.00	06900 ELECTROCARDIOLOGY	0.067601	8,369	566	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901	205,054	39,760	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.526432	351,528	185,056	73.00
73.01	07301 CARDIAC REHABILITATION	0.959929	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000 CLINIC	1.298820	0	0	90.00
91.00	09100 EMERGENCY	0.829660	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.291924	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,461,395	590,022	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)		1,461,395		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 4:51 pm	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.654110	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.313898	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.232879	0	0	54.00
60.00	06000 LABORATORY	0.210795	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.487928	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.501592	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.656495	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.791004	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.067601	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.193901	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.526432	0	0	73.00
73.01	07301 CARDIAC REHABILITATION	0.959929	0	0	73.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.207877	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHC	1.853865	0	0	88.01
90.00	09000 CLINIC	1.298820	0	0	90.00
91.00	09100 EMERGENCY	0.829660	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.291924	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 4:51 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,713,819	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)		4,713,819	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		4,760,957	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)		48,896	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,824,542	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,887,519	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,887,519	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,887,519	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)		59,405	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		38,613	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,405	36.00
37.00	Subtotal (see instructions)		2,926,132	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,926,132	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,253,591	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)		-327,459	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 4:51 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,239,696		3,253,591	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/25/2021	155,300		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)		155,300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,394,996		3,253,591	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		134,412		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		327,459	6.02
7.00	Total Medicare program liability (see instructions)		1,529,408		2,926,132	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		05901		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1331

Period:

Worksheet E-1

Component CCN: 14-Z331

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 4:51 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,238,969		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/25/2021	175,500		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)		175,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,414,469		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		90,850		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,505,319		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES		05901		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/23/2021 4:51 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2
		Component CCN: 14-Z331		Date/Time Prepared: 11/23/2021 4:51 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,918,406	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
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)		595,922	0
3.01	Nursing and allied health payment-PARHM (see instructions)			0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		774	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,514,328	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		2,514,328	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		2,514,328	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		9,009	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (see instructions)		2,505,319	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0	0
16.99	Demonstration payment adjustment amount before sequestration		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		2,505,319	0
19.01	Sequestration adjustment (see instructions)		0	0
19.02	Demonstration payment adjustment amount after sequestration		0	0
19.03	Sequestration adjustment-PARHM pass-throughs			0
19.25	Sequestration for non-claims based amounts (see instructions)		0	0
20.00	Interim payments		2,414,469	0
20.01	Interim payments-PARHM			0
21.00	Tentative settlement (for contractor use only)		0	0
21.01	Tentative settlement-PARHM (for contractor use only)			0
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		90,850	0
22.01	Balance due provider/program-PARHM (see instructions)			0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0
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: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/23/2021 4:51 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,613,243	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,613,243	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,629,375	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,629,375	19.00
20.00	Deductibles (exclude professional component)		162,332	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,467,043	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,467,043	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		95,946	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		62,365	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		95,946	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,529,408	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,529,408	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,394,996	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		134,412	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1331	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2021 4:51 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1331

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

Worksheet G

Date/Time Prepared:
11/23/2021 4:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	11,346,440	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,802,107	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-919,968	0	0	0	6.00
7.00	Inventory	557,362	0	0	0	7.00
8.00	Prepaid expenses	1,337,787	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,123,728	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,114	0	0	0	12.00
13.00	Land improvements	1,260,841	0	0	0	13.00
14.00	Accumulated depreciation	-1,106,472	0	0	0	14.00
15.00	Buildings	7,674,169	0	0	0	15.00
16.00	Accumulated depreciation	-5,131,040	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,010,612	0	0	0	19.00
20.00	Accumulated depreciation	-5,631,925	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	5,688,401	0	0	0	23.00
24.00	Accumulated depreciation	-4,705,052	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	1,586,972	0	0	0	27.00
28.00	Accumulated depreciation	-1,397,125	0	0	0	28.00
29.00	Minor equipment-nondepreciable	459,267	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,711,762	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	8,331,901	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	176,877	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,508,778	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,344,268	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,284,514	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,901,994	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,784,521	0	0	0	40.00
41.00	Deferred income	244,455	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	4,966,964	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,182,448	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,578,650	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	660,900	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,239,550	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,421,998	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,922,270				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)	12,922,270	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,344,268	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1331

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

Worksheet G-1

Date/Time Prepared:
11/23/2021 4:51 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,834,984		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,780,288				2.00
3.00	Total (sum of line 1 and line 2)		12,615,272		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	307,000		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)		307,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,922,272		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	RELEASED FROM RESTRICTION	0		0		0	13.00
14.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,922,270		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	RESTRICTED CONTRIBUTIONS		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	RELEASED FROM RESTRICTION		0				13.00
14.00	ROUNDING		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: 14-1331

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 4:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	650,158		650,158	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	407,021		407,021	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)	1,057,179		1,057,179	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,057,179		1,057,179	17.00
18.00	Ancillary services	4,291,133	32,967,246	37,258,379	18.00
19.00	Outpatient services	0	1,425,717	1,425,717	19.00
20.00	RURAL HEALTH CLINIC	0	2,468,249	2,468,249	20.00
20.01	RURAL HEALTH CLINIC II - FHC	0	474,882	474,882	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUES	0	451,945	451,945	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,348,312	37,788,039	43,136,351	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,297,580		29.00
30.00	BAD DEBT EXPENSE	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)		25,297,580		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1331

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

Worksheet G-3

Date/Time Prepared:
11/23/2021 4:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,136,351	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,586,833	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,549,518	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,297,580	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,748,062	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	18,875	6.00
7.00	Income from investments	1,084,489	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	27,352	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	46,566	14.00
15.00	Revenue from rental of living quarters	240,735	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	84,855	17.00
18.00	Revenue from sale of medical records and abstracts	-1,090	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	7,754	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PROGRAM (NET OF EXPENSES)	915,118	24.00
24.01	OTHER INCOME	97,336	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.50	COVID-19 PHE Funding	5,014,905	24.50
25.00	Total other income (sum of lines 6-24)	7,536,895	25.00
26.00	Total (line 5 plus line 25)	5,788,833	26.00
27.00	LOSS ON SALE OF EQUIPMENT	8,545	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	8,545	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,780,288	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8504

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		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	607,112	0	607,112	5,132	612,244
2.00	Physician Assistant	166,554	0	166,554	0	166,554
3.00	Nurse Practitioner	309,519	0	309,519	25,129	334,648
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	111,204	0	111,204	26,902	138,106
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)	1,194,389	0	1,194,389	57,163	1,251,552
11.00	Physician Services Under Agreement	0	388,743	388,743	0	388,743
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	388,743	388,743	0	388,743
15.00	Medical Supplies	0	57,841	57,841	0	57,841
16.00	Transportation (Health Care Staff)	0	17,466	17,466	0	17,466
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	75,307	75,307	0	75,307
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,194,389	464,050	1,658,439	57,163	1,715,602
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	7,518	7,518	0	7,518
30.00	Administrative Costs	304,564	52,179	356,743	82,895	439,638
31.00	Total Facility Overhead (sum of lines 29 and 30)	304,564	59,697	364,261	82,895	447,156
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,498,953	523,747	2,022,700	140,058	2,162,758

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8504

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	612,244	1.00
2.00	Physician Assistant	0	166,554	2.00
3.00	Nurse Practitioner	0	334,648	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	138,106	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,251,552	10.00
11.00	Physician Services Under Agreement	0	388,743	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	388,743	14.00
15.00	Medical Supplies	0	57,841	15.00
16.00	Transportation (Health Care Staff)	0	17,466	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	75,307	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,715,602	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	7,518	29.00
30.00	Administrative Costs	-810	438,828	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-810	446,346	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-810	2,161,948	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8597

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		RHC II		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	128,513	0	128,513	10,106	138,619
3.00	Nurse Practitioner	157,534	0	157,534	13,619	171,153
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	151,851	0	151,851	0	151,851
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	6,574	0	6,574	0	6,574
10.00	Subtotal (sum of lines 1 through 9)	444,472	0	444,472	23,725	468,197
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	16,858	16,858	0	16,858
16.00	Transportation (Health Care Staff)	0	729	729	0	729
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	17,587	17,587	0	17,587
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	444,472	17,587	462,059	23,725	485,784
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	7,714	7,714	0	7,714
30.00	Administrative Costs	48,499	9,799	58,298	41,702	100,000
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,499	17,513	66,012	41,702	107,714
32.00	Total facility costs (sum of lines 22, 28 and 31)	492,971	35,100	528,071	65,427	593,498

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331

Period:

Worksheet M-1

Component CCN: 14-8597

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	138,619	2.00
3.00	Nurse Practitioner	0	171,153	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	151,851	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	6,574	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	468,197	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	16,858	15.00
16.00	Transportation (Health Care Staff)	0	729	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	17,587	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	485,784	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	7,714	29.00
30.00	Administrative Costs	-323	99,677	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-323	107,391	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-323	593,175	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331

Period:

Worksheet M-2

Component CCN: 14-8504

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.97	2,844	1,450	2,857		1.00
2.00	Physician Assistant	0.91	1,776	1,950	1,775		2.00
3.00	Nurse Practitioner	2.21	4,467	2,000	4,420		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.09	9,087		9,052	9,087	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)	5.09	9,087			9,087	8.00
9.00	Physician Services Under Agreements		638			638	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)					1,715,602	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)					1,715,602	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)					446,346	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					819,392	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,265,738	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,265,738	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,265,738	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,981,340	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331

Period:

Worksheet M-2

Component CCN: 14-8597

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.70	1,709	2,450	1,715		2.00
3.00	Nurse Practitioner	0.90	1,307	1,450	1,305		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.60	3,016		3,020	3,020	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)	1.60	3,016			3,020	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)					485,784	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)					485,784	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)					107,391	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					287,192	15.00
16.00	Total overhead (sum of lines 14 and 15)					394,583	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					394,583	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					394,583	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					880,367	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1331 Component CCN: 14-8504	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 4:51 pm	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,981,340	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			46,614	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,934,726	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,087	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			638	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,725	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			301.77	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	251.09	8.00
9.00	Rate for Program covered visits (see instructions)	301.77	301.77	251.09	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	1,506	753	753	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	454,466	227,233	189,071	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	870,770		16.00
16.01	Total program charges (see instructions)(from contractor's records)		461,348		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,127		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,790		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.)		648,746		16.04
16.05	Total program cost (see instructions)	0	656,536		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		52,048		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		81,035		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		656,536		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,357		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		685,893		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)		685,893		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		510,476		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)		175,417		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: 14-1331 Component CCN: 14-8597	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 4:51 pm	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			880,367	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,278	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			868,089	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,020	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)			3,020	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			287.45	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	236.16	8.00
9.00	Rate for Program covered visits (see instructions)	287.45	287.45	236.16	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	497	249	248	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	142,863	71,575	58,568	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	273,006		16.00
16.01	Total program charges (see instructions)(from contractor's records)		157,527		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,636		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,035		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.)		198,377		16.04
16.05	Total program cost (see instructions)	0	206,412		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,000		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		27,178		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		206,412		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,822		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		212,234		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)		212,234		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		195,526		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)		16,708		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: 14-1331

Period:

Worksheet M-4

Component CCN: 14-8504

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,251,552	1,251,552	1,251,552	1,251,552	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000329	0.001583	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	412	1,981	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,432	14,999	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,844	16,980	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,715,602	1,715,602	1,715,602	1,715,602	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,265,738	1,265,738	1,265,738	1,265,738	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005738	0.009897	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,263	12,527	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,107	29,507	0	0	10.00
11.00	Total number of injections/infusions (from your records)	60	289	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	285.12	102.10	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	36	187	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)	10,264	19,093	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)		46,614			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)		29,357			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1331

Period:

Worksheet M-4

Component CCN: 14-8597

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 4:51 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	468,197	468,197	468,197	468,197	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000062	0.000144	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	29	67	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,773	2,906	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,802	2,973	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	485,784	485,784	485,784	485,784	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	394,583	394,583	394,583	394,583	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007827	0.006120	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,088	2,415	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,890	5,388	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	56	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	275.60	96.21	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	29	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)	3,032	2,790	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)		12,278			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)		5,822			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1331 Component CCN: 14-8504	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 4:51 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		510,476	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)		510,476		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		175,417		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		685,893		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1331 Component CCN: 14-8597	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 4:51 pm	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		195,526	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)		195,526		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		16,708		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		212,234		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00