

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: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/19/2021 10:01 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/19/2021	Time: 10:01 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 MEMORIAL HOSPITAL (14-1338) 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)

Officer or Administrator of Provider(s)

Title

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	-162,165	58,574	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	-46,898	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		268,854		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
200.00	Total	0	-209,063	327,428	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1900 STATE STREET			PO Box:				1.00		
2.00	City: CHESTER			State: IL		Zip Code: 62233		County: RANDOLPH		
		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		MEMORIAL HOSPITAL	141338	99914	1	09/01/2004	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL-SWING BEDS	142338	99914		09/01/2004	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		CHESTER CLINIC	148543	99914		06/01/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		STEELEVILLE FAMILY PRACTICE	148542	99914		06/01/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						8			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N					60.00
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20	
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/19/2021 10:01 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	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.	N		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.	N		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.	N		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.	N		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.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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			
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			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	325,465		0		118.01	
				1.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am	
				1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	Removed and reserved							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N				140.00	
1.00				2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:			Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:			PO Box:				142.00	
143.00	City:			State:		Zip Code:		143.00	
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
								4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N		N		N	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
						1.00			
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
				Name		County		State	
				0		1.00		2.00	
						Zip Code		CBSA	
						3.00		4.00	
								FTE/Campus	
								5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/19/2021 10:01 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/19/2021 10:01 am	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N 1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	11/10/2021	Y	11/10/2021
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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/19/2021 10:01 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
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.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 10:01 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	25,337.54	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	25,337.54	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	25,337.54	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 RHC (CONSOLIDATED)	88.00				0	26.00
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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 10:01 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	598	17	1,077		1.00
2.00	HMO and other (see instructions)	230	45			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	487	0	764		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	47		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,085	17	1,888		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)	1,085	17	1,888	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	RHC (CONSOLIDATED)	5,091	199	17,908	0.00	38.95
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	218.28
28.00	Observation Bed Days		6	149		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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/19/2021 10:01 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	147	4	276	1.00
2.00 HMO and other (see instructions)			55	12		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	147	4	276	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 RHC (CONSOLIDATED)	0.00					26.00
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

MCRIF32 - 16.12.172.5

Health Financial Systems		MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1338	Period: From 07/01/2020	Worksheet S-8
			Component CCN: 14-8543	To 06/30/2021	Date/Time Prepared: 11/19/2021 10:01 am
			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	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1338

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

Worksheet S-10

Date/Time Prepared:
11/19/2021 10:01 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.535605	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,961,196	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		5,005,141	6.00
7.00	Medicaid cost (line 1 times line 6)		2,680,779	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)		719,583	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)		719,583	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	76,118	33,718	109,836
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	40,769	33,718	74,487
22.00	Payments received from patients for amounts previously written off as charity care	3,960	5,154	9,114
23.00	Cost of charity care (line 21 minus line 22)	36,809	28,564	65,373
			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)		843,727	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		140,845	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		216,685	27.01
28.00	Non-Medicare bad debt expense (see instructions)		627,042	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		411,687	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		477,060	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,196,643	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,427,697	1,427,697	-657,529	770,168	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	848,543	848,543	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	140,401	2,808,130	2,948,531	0	2,948,531	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,458,622	1,427,991	2,886,613	482,625	3,369,238	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	495,757	519,430	1,015,187	-65	1,015,122	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,732	53,462	111,194	0	111,194	8.00
9.00	00900	HOUSEKEEPING	344,354	89,210	433,564	0	433,564	9.00
10.00	01000	DIETARY	371,054	214,266	585,320	-425,117	160,203	10.00
11.00	01100	CAFETERIA	0	0	0	425,117	425,117	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	337,508	51,679	389,187	0	389,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,400	650,097	722,497	-631,349	91,148	14.00
15.00	01500	PHARMACY	378,123	854,969	1,233,092	-753,096	479,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	521,185	73,798	594,983	0	594,983	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	1,762,147	221,889	1,984,036	114,778	2,098,814	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	706,234	264,979	971,213	-66,032	905,181	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,299	692,243	1,362,542	0	1,362,542	54.00
60.00	06000	LABORATORY	717,869	1,073,664	1,791,533	-21,966	1,769,567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,319	48,141	67,460	0	67,460	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	60,236	60,236	64.00
65.00	06500	RESPIRATORY THERAPY	237,038	105,139	342,177	-2,748	339,429	65.00
66.00	06600	PHYSICAL THERAPY	0	445,349	445,349	0	445,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	65,717	65,717	0	65,717	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,827	68,827	0	68,827	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	457,740	457,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	173,609	173,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	753,096	753,096	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	243,458	1,686,794	1,930,252	-44,927	1,885,325	76.01
76.02	03020	WOUND CARE	0	137,385	137,385	0	137,385	76.02
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	2,916,942	2,535,329	5,452,271	-710,652	4,741,619	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	205,145	93,029	298,174	0	298,174	90.00
91.00	09100	EMERGENCY	857,373	1,834,295	2,691,668	-2,263	2,689,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,512,960	17,443,509	29,956,469	0	29,956,469	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,821	288	4,109	0	4,109	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,516,781	17,443,797	29,960,578	0	29,960,578	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/19/2021 10:01 am

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	0	770,168	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-231	848,312	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,948,531	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-213,503	3,155,735	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,058	1,011,064	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	111,194	8.00
9.00	00900	HOUSEKEEPING	0	433,564	9.00
10.00	01000	DIETARY	-158	160,045	10.00
11.00	01100	CAFETERIA	-47,600	377,517	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	389,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-240	90,908	14.00
15.00	01500	PHARMACY	-96,623	383,373	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,496	582,487	16.00
17.00	01700	SOCIAL SERVICE	0	0	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	-128,189	1,970,625	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	905,181	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,362,542	54.00
60.00	06000	LABORATORY	0	1,769,567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	67,460	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	60,236	64.00
65.00	06500	RESPIRATORY THERAPY	-52,858	286,571	65.00
66.00	06600	PHYSICAL THERAPY	0	445,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	65,717	67.00
68.00	06800	SPEECH PATHOLOGY	-39,726	29,101	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	457,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	173,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-71,487	681,609	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.01	03951	CHEMOTHERAPY	-154,525	1,730,800	76.01
76.02	03020	WOUND CARE	-29,610	107,775	76.02
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	-1,087,844	3,653,775	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	-63,727	234,447	90.00
91.00	09100	EMERGENCY	-1,222,602	1,466,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,225,477	26,730,992	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,109	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,225,477	26,735,101	200.00

RECLASSIFICATIONS

Provider CCN: 14-1338

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

Worksheet A-6

Date/Time Prepared:
11/19/2021 10:01 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DRUG COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	753,096		1.00
	0		0	753,096		
	B - RECLASS DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	755,590		1.00
	0		0	755,590		
	C - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	457,740		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	173,609		2.00
	PATIENTS					
	0		0	631,349		
	F - CAFETERIA					
1.00	CAFETERIA	11.00	269,496	155,621		1.00
	0		269,496	155,621		
	H - LEASE/RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	92,953		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	92,953		
	I - RHC ADMINISTRATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	319,942	262,918		1.00
	0		319,942	262,918		
	L - RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,061		1.00
	0		0	98,061		
	M - TO RECLASS IV THERAPY EXPENSE					
1.00	INTRAVENOUS THERAPY	64.00	56,075	4,161		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		56,075	4,161		
	N - TO RECLASS RHC HOSPITALIST EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	97,693	30,099		1.00
	0		97,693	30,099		
500.00	Grand Total: Increases		743,206	2,783,848		500.00

RECLASSIFICATIONS

Provider CCN: 14-1338

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

Worksheet A-6

Date/Time Prepared:
11/19/2021 10:01 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS DRUG COST						
	PHARMACY _____	15.00	0	753,096	0		1.00
	0		0	753,096			
1.00	B - RECLASS DEPRECIATION						
	CAP REL COSTS-BLDG & FIXT _____	1.00	0	755,590	9		1.00
	0		0	755,590			
1.00	C - RECLASS MEDICAL SUPPLIES						
	CENTRAL SERVICES & SUPPLY	14.00	0	631,349	0		1.00
2.00	_____	0.00	0	0	0		2.00
	0		0	631,349			
1.00	F - CAFETERIA						
	DIETARY _____	10.00	269,496	155,621	0		1.00
	0		269,496	155,621			
1.00	H - LEASE/RENTAL						
	ADMINISTRATIVE & GENERAL	5.00	0	2,174	10		1.00
2.00	OPERATION OF PLANT	7.00	0	65	0		2.00
3.00	OPERATING ROOM	50.00	0	66,000	0		3.00
4.00	LABORATORY	60.00	0	21,966	0		4.00
5.00	RESPIRATORY THERAPY _____	65.00	0	2,748	0		5.00
	0		0	92,953			
1.00	I - RHC ADMINISTRATION						
	RURAL HEALTH CLINIC _____	88.00	319,942	262,918	0		1.00
	0		319,942	262,918			
1.00	L - RECLASS PROPERTY INSURANCE						
	ADMINISTRATIVE & GENERAL _____	5.00	0	98,061	12		1.00
	0		0	98,061			
1.00	M - TO RECLASS IV THERAPY EXPENSE						
	EMERGENCY	91.00	2,104	159	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	12,115	899	0		2.00
3.00	CHEMOTHERAPY	76.01	41,826	3,101	0		3.00
4.00	OPERATING ROOM _____	50.00	30	2	0		4.00
	0		56,075	4,161			
1.00	N - TO RECLASS RHC HOSPITALIST EXPENSE						
	RURAL HEALTH CLINIC _____	88.00	97,693	30,099	0		1.00
	0		97,693	30,099			
500.00	Grand Total: Decreases		743,206	2,783,848			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/19/2021 10:01 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	232,983	0	0	0	0	1.00	
2.00	Land Improvements	699,764	0	0	0	0	2.00	
3.00	Buildings and Fixtures	20,818,865	920,599	0	920,599	139	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	1,000,778	45,352	0	45,352	0	5.00	
6.00	Movable Equipment	12,277,412	680,600	0	680,600	253,287	6.00	
7.00	HIT designated Assets	1,560,155	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	36,589,957	1,646,551	0	1,646,551	253,426	8.00	
9.00	Reconciling Items	3,395,913	0	0	0	2,822,055	9.00	
10.00	Total (line 8 minus line 9)	33,194,044	1,646,551	0	1,646,551	-2,568,629	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	232,983	0				1.00	
2.00	Land Improvements	699,764	0				2.00	
3.00	Buildings and Fixtures	21,739,325	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	1,046,130	0				5.00	
6.00	Movable Equipment	12,704,725	0				6.00	
7.00	HIT designated Assets	1,560,155	0				7.00	
8.00	Subtotal (sum of lines 1-7)	37,983,082	0				8.00	
9.00	Reconciling Items	573,858	0				9.00	
10.00	Total (line 8 minus line 9)	37,409,224	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,427,697	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,427,697	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)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,427,697				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,427,697				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,718,202	0	23,718,202	0.624441	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,264,880	0	14,264,880	0.375559	0	2.00
3.00	Total (sum of lines 1-2)	37,983,082	0	37,983,082	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	672,107	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	755,359	92,953	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,427,466	92,953	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	98,061	0	0	770,168	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	848,312	2.00
3.00	Total (sum of lines 1-2)	0	98,061	0	0	1,618,480	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-96,623	PHARMACY	15.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-397	ADULTS & PEDIATRICS	30.00	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	-1,690,840			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-4,058	OPERATION OF PLANT	7.00	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	-47,600	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-71,487	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,496	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN 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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-231	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NON ALLOW LOBBYING DUES	A	-8,737	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	NON ALLOW SALARY	A	-78	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	NON ALLOW OTHER	A	-48,624	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	CRNA AND SURGEON BILLING EXPENSE	A	-147,890	ADMINISTRATIVE & GENERAL	5.00	0	35.02
40.00	RHC CRNA EXPENSE	A	-615,703	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	RHC SURGEON	A	-383,957	RURAL HEALTH CLINIC	88.00	0	41.00
42.00	RHC PHYSICIAN FEES	A	-872	RURAL HEALTH CLINIC	88.00	0	42.00
44.01	NON ALLOW DR MEALS	A	-158	DIETARY	10.00	0	44.01
45.00	REIMB. OF SALARY EXP	B	-989	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	NON OP REV	B	-7,974	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	NON OP REV	B	-240	CENTRAL SERVICES & SUPPLY	14.00	0	45.02
45.03	RHC LAB CHARGES	A	-86,323	RURAL HEALTH CLINIC	88.00	0	45.03
45.04	ROTARY FOR CEO	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,225,477				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: 14-1338

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

Worksheet A-8-2

Date/Time Prepared:
11/19/2021 10:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	127,792	127,792	0	0	0	1.00
2.00	76.02	AGGREGATE-WOUND CARE	29,610	29,610	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	63,727	63,727	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,689,615	1,222,602	467,013	0	0	4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	154,525	154,525	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	20,400	0	20,400	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	52,858	52,858	0	0	0	7.00
8.00	68.00	AGGREGATE-SPEECH PATHOLOGY	39,726	39,726	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			2,178,253	1,690,840	487,413			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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	76.02	AGGREGATE-WOUND CARE	0	0	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	68.00	AGGREGATE-SPEECH PATHOLOGY	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	127,792		1.00
2.00	76.02	AGGREGATE-WOUND CARE	0	0	0	29,610		2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	63,727		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,222,602		4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	154,525		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	52,858		7.00
8.00	68.00	AGGREGATE-SPEECH PATHOLOGY	0	0	0	39,726		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	1,690,840		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am		
				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)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.62	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	3,879.00	3,325.30	1,921.30	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	85.51	64.13	42.75	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)	42.76	42.76	32.07			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)						331,693	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						213,251	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						544,944	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						82,136	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)						627,080	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						627,080	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)						0	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)						0	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)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	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)						0	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: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am		
				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)	85.51	64.13	42.75	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)						627,080	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						627,080	63.00
64.00	Total cost of outside supplier services (from your records)						429,836	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						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	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						0	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						0	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: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.62	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	918.80	830.10	64.80	0.00	0.00	9.00
10.00	AHSEA (see instructions)	101.32	81.06	60.79	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.53	40.53	30.40			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)					93,093	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					67,288	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					3,939	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					164,320	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)					164,320	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					164,320	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am		
				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)	81.06	60.79	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)						164,320	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						164,320	63.00
64.00	Total cost of outside supplier services (from your records)						65,717	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						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	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						0	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						0	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: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am		
				Speech Pathology		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)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.62	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	174.10	786.70	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	97.36	77.89	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.95	38.95	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						16,950	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						61,276	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)						78,226	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)						78,226	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						78,226	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)						0	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)						0	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)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	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)						0	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: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2021 10:01 am		
				Speech Pathology		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)	77.89	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)						78,226	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						78,226	63.00
64.00	Total cost of outside supplier services (from your records)						28,950	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						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	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						0	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						0	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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/19/2021 10:01 am

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	770,168	770,168			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	848,312		848,312		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,948,531	7,601	8,372	2,964,504	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,155,735	134,739	148,414	533,798	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,011,064	106,621	117,439	148,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,194	6,331	6,973	17,328	8.00
9.00	00900	HOUSEKEEPING	433,564	14,580	16,059	103,355	9.00
10.00	01000	DIETARY	160,045	5,558	6,122	30,482	10.00
11.00	01100	CAFETERIA	377,517	21,718	23,922	80,887	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	389,187	13,994	15,413	101,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,908	10,655	11,736	21,730	14.00
15.00	01500	PHARMACY	383,373	7,006	7,716	113,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	582,487	15,885	17,497	156,430	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	1,970,625	87,895	96,813	554,584	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	905,181	75,029	82,641	211,961	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,542	36,049	39,707	201,185	54.00
60.00	06000	LABORATORY	1,769,567	24,569	27,061	215,463	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	67,460	1,279	1,408	5,798	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	60,236	0	0	16,830	64.00
65.00	06500	RESPIRATORY THERAPY	286,571	15,414	16,978	71,145	65.00
66.00	06600	PHYSICAL THERAPY	445,349	80,711	88,901	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,717	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,101	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	457,740	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	173,609	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	681,609	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	1,730,800	18,877	20,792	60,518	76.01
76.02	03020	WOUND CARE	107,775	2,504	2,758	0	76.02
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	3,653,775	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	234,447	24,675	27,179	61,573	90.00
91.00	09100	EMERGENCY	1,466,803	40,169	44,245	256,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,730,992	751,859	828,146	2,963,357	26,691,370
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,109	7,743	8,528	1,147	21,527
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,159	5,682	0	10,841
193.01	19301	AFTER CARE PROGRAM	0	5,407	5,956	0	11,363
194.00	07950	NON-ALLOWABLE COSTS	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)	26,735,101	770,168	848,312	2,964,504	26,735,101

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,972,686					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	241,533	0	1,625,454			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,753	0	19,744	186,323		8.00
9.00	00900	HOUSEKEEPING	99,055	0	45,468	0	712,081	9.00
10.00	01000	DIETARY	35,291	0	17,334	0	7,911	10.00
11.00	01100	CAFETERIA	87,970	0	67,732	0	30,912	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	90,736	0	43,641	0	19,917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,566	0	33,229	0	15,165	14.00
15.00	01500	PHARMACY	89,286	0	21,848	0	9,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	134,788	0	49,539	0	22,609	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	472,956	0	274,113	186,323	125,104	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	222,490	0	233,988	0	106,790	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	286,136	0	112,425	0	51,310	54.00
60.00	06000	LABORATORY	355,454	0	76,621	0	34,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,255	0	3,987	0	1,820	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	13,450	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	68,085	0	48,071	0	21,939	65.00
66.00	06600	PHYSICAL THERAPY	107,328	0	251,710	0	114,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,469	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,079	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,888	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,300	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,960	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	319,558	0	58,871	0	26,868	76.01
76.02	03020	WOUND CARE	19,728	0	7,809	0	3,564	76.02
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	637,694	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	60,714	0	76,953	0	35,121	90.00
91.00	09100	EMERGENCY	315,532	0	125,273	0	57,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,965,054	0	1,568,356	186,323	686,022	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,757	0	24,146	0	11,020	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,892	0	16,088	0	7,343	192.00
193.01	19301	AFTER CARE PROGRAM	1,983	0	16,864	0	7,696	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,972,686	0	1,625,454	186,323	712,081	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	262,743					10.00
11.00	01100	CAFETERIA	0	690,658				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	34,131	0	708,319		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,322	0	0	214,311	14.00
15.00	01500	PHARMACY	0	38,238	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,706	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	262,743	186,855	0	362,459	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	71,416	0	138,533	10,325	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,785	0	0	2,121	54.00
60.00	06000	LABORATORY	0	72,596	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,954	0	0	113	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	5,671	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	23,971	0	0	1,901	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	135,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	48,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	20,390	0	39,553	4,498	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	5,009	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	20,746	0	0	507	90.00
91.00	09100	EMERGENCY	0	86,491	0	167,774	5,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,743	690,272	0	708,319	214,311	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	386	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
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)	262,743	690,658	0	708,319	214,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
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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	670,929					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,031,941				16.00
17.00	01700	SOCIAL SERVICE	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			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	47,432	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	53,259	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,615	0	0	0	54.00
60.00	06000	LABORATORY	0	240,604	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,431	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	6,065	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	39,002	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	46,250	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,818	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,699	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	100,575	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,652	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,209	58,940	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	420,453	93,742	0	0	0	76.01
76.02	03020	WOUND CARE	0	8,859	0	0	0	76.02
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	38,267	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	7,759	0	0	0	90.00
91.00	09100	EMERGENCY	0	69,239	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	670,929	1,031,941	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
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
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)	670,929	1,031,941	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	4,627,902	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,111,613	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,395,875	0	54.00
60.00	06000	LABORATORY	0	0	0	2,816,904	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	101,505	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	102,252	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	593,077	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,135,287	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	83,004	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	39,879	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	773,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	260,236	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,071,718	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	2,814,920	0	76.01
76.02	03020	WOUND CARE	0	0	0	152,997	0	76.02
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	4,334,745	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	549,674	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,635,014	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	26,600,195	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	60,836	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	36,164	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	37,906	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
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	26,735,101	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
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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
		4,627,902	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.01	03951	CHEMOTHERAPY	76.01
76.02	03020	WOUND CARE	76.02
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	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			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		26,600,195	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.01	19301	AFTER CARE PROGRAM	193.01
194.00	07950	NON-ALLOWABLE COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		26,735,101	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
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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	7,601	8,372	15,973	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	134,739	148,414	283,153	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	106,621	117,439	224,060	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,331	6,973	13,304	8.00
9.00	00900	HOUSEKEEPING	0	14,580	16,059	30,639	9.00
10.00	01000	DIETARY	0	5,558	6,122	11,680	10.00
11.00	01100	CAFETERIA	0	21,718	23,922	45,640	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	13,994	15,413	29,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,655	11,736	22,391	14.00
15.00	01500	PHARMACY	0	7,006	7,716	14,722	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,885	17,497	33,382	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	87,895	96,813	184,708	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	75,029	82,641	157,670	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,049	39,707	75,756	54.00
60.00	06000	LABORATORY	0	24,569	27,061	51,630	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,279	1,408	2,687	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,414	16,978	32,392	65.00
66.00	06600	PHYSICAL THERAPY	0	80,711	88,901	169,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	18,877	20,792	39,669	76.01
76.02	03020	WOUND CARE	0	2,504	2,758	5,262	76.02
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	0	0	0	0	88.01
90.00	09000	CLINIC	0	24,675	27,179	51,854	90.00
91.00	09100	EMERGENCY	0	40,169	44,245	84,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	751,859	828,146	1,580,005	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,743	8,528	16,271	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,159	5,682	10,841	192.00
193.01	19301	AFTER CARE PROGRAM	0	5,407	5,956	11,363	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	770,168	848,312	1,618,480	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
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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	286,029					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	17,390	0	242,252			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,782	0	2,943	18,122		8.00
9.00	00900	HOUSEKEEPING	7,132	0	6,776	0	45,104	9.00
10.00	01000	DIETARY	2,541	0	2,583	0	501	10.00
11.00	01100	CAFETERIA	6,334	0	10,095	0	1,958	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,533	0	6,504	0	1,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,697	0	4,952	0	961	14.00
15.00	01500	PHARMACY	6,429	0	3,256	0	632	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,705	0	7,383	0	1,432	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	34,053	0	40,854	18,122	7,922	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,019	0	34,873	0	6,764	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,602	0	16,755	0	3,250	54.00
60.00	06000	LABORATORY	25,593	0	11,419	0	2,215	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	954	0	594	0	115	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	968	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,902	0	7,164	0	1,390	65.00
66.00	06600	PHYSICAL THERAPY	7,728	0	37,514	0	7,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	826	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	366	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,752	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,182	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,565	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	23,008	0	8,774	0	1,702	76.01
76.02	03020	WOUND CARE	1,420	0	1,164	0	226	76.02
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	45,909	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	4,371	0	11,469	0	2,225	90.00
91.00	09100	EMERGENCY	22,718	0	18,670	0	3,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,479	0	233,742	18,122	43,453	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	271	0	3,599	0	698	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	136	0	2,398	0	465	192.00
193.01	19301	AFTER CARE PROGRAM	143	0	2,513	0	488	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	286,029	0	242,252	18,122	45,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

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	17,469					10.00
11.00	01100	CAFETERIA	0	64,463				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,186	0	47,438		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	683	0	0	30,801	14.00
15.00	01500	PHARMACY	0	3,569	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,919	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	17,469	17,441	0	24,274	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,666	0	9,278	1,484	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,327	0	0	305	54.00
60.00	06000	LABORATORY	0	6,776	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	182	0	0	16	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	529	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,237	0	0	273	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	23	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	19,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	1,903	0	2,649	646	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	720	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	1,936	0	0	73	90.00
91.00	09100	EMERGENCY	0	8,073	0	11,237	807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,469	64,427	0	47,438	30,801	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	36	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,469	64,463	0	47,438	30,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
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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	29,219					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,664				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	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	2,651	0			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,977	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,225	0			54.00
60.00	06000	LABORATORY	0	13,433	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	248	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	339	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	2,180	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,585	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	325	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	319	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,621	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	428	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,242	3,294	0			73.00
76.00	03950	CARDIAC REHAB	0	0	0			76.00
76.01	03951	CHEMOTHERAPY	18,310	5,240	0			76.01
76.02	03020	WOUND CARE	0	495	0			76.02
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	1,667	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	0	434	0			90.00
91.00	09100	EMERGENCY	0	3,870	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,219	57,664	0	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
193.01	19301	AFTER CARE PROGRAM	0	0	0			193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0			194.00
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)	29,219	57,664	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/19/2021 10:01 am

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				350,483	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				236,873	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				137,304	0	54.00
60.00	06000	LABORATORY				112,227	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				4,827	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				1,927	0	64.00
65.00	06500	RESPIRATORY THERAPY				50,921	0	65.00
66.00	06600	PHYSICAL THERAPY				224,739	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				1,151	0	67.00
68.00	06800	SPEECH PATHOLOGY				685	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				30,831	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				9,606	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				21,101	0	73.00
76.00	03950	CARDIAC REHAB				0	0	76.00
76.01	03951	CHEMOTHERAPY				102,227	0	76.01
76.02	03020	WOUND CARE				8,567	0	76.02
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				48,296	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				0	0	88.01
90.00	09000	CLINIC				72,694	0	90.00
91.00	09100	EMERGENCY				154,793	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,569,252	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				20,881	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES				13,840	0	192.00
193.01	19301	AFTER CARE PROGRAM				14,507	0	193.01
194.00	07950	NON-ALLOWABLE COSTS				0	0	194.00
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	1,618,480	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/19/2021 10:01 am

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
		350,483	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.01	03951	CHEMOTHERAPY	76.01
76.02	03020	WOUND CARE	76.02
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	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			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		1,569,252	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.01	19301	AFTER CARE PROGRAM	193.01
194.00	07950	NON-ALLOWABLE COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		1,618,480	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQ FEET)	MOVBLE EQUIP (SQ FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	86,739					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		86,739				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	856	856	9,876,995			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,175	15,175	1,778,486	-3,972,686	22,762,415	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,008	12,008	495,757	0	1,383,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713	713	57,732	0	141,826	8.00
9.00	00900	HOUSEKEEPING	1,642	1,642	344,354	0	567,558	9.00
10.00	01000	DIETARY	626	626	101,558	0	202,207	10.00
11.00	01100	CAFETERIA	2,446	2,446	269,496	0	504,044	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,576	1,576	337,508	0	519,894	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,200	1,200	72,400	0	135,029	14.00
15.00	01500	PHARMACY	789	789	378,123	0	511,586	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,789	1,789	521,185	0	772,299	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	9,899	9,899	1,847,725	0	2,709,917	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,450	8,450	706,204	0	1,274,812	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,060	4,060	670,299	0	1,639,483	54.00
60.00	06000	LABORATORY	2,767	2,767	717,869	0	2,036,660	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144	144	19,319	0	75,945	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	56,075	0	77,066	64.00
65.00	06500	RESPIRATORY THERAPY	1,736	1,736	237,038	0	390,108	65.00
66.00	06600	PHYSICAL THERAPY	9,090	9,090	0	0	614,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	65,717	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	29,101	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	457,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	173,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	681,609	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,126	2,126	201,632	0	1,830,987	76.01
76.02	03020	WOUND CARE	282	282	0	0	113,037	76.02
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	3,653,775	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	2,779	2,779	205,145	0	347,874	90.00
91.00	09100	EMERGENCY	4,524	4,524	855,269	0	1,807,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,677	84,677	9,873,174	-3,972,686	22,718,684	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	872	872	3,821	0	21,527	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	581	581	0	0	10,841	192.00
193.01	19301	AFTER CARE PROGRAM	609	609	0	0	11,363	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	770,168	848,312	2,964,504		3,972,686	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.879143	9.780053	0.300142		0.174528	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,973		286,029	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001617		0.012566	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQ FEET)	MVBLE EQUIP (SQ FEET)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			MAINTENANCE & REPAIRS (GROSS SALARIES)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQ FEET)	DIETARY (PATIENT DA YS)	
			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	0					6.00
7.00	00700	OPERATION OF PLANT	0	58,700				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	713	1,077			8.00
9.00	00900	HOUSEKEEPING	0	1,642	0	56,345		9.00
10.00	01000	DIETARY	0	626	0	626	1,077	10.00
11.00	01100	CAFETERIA	0	2,446	0	2,446	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,576	0	1,576	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,200	0	1,200	0	14.00
15.00	01500	PHARMACY	0	789	0	789	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,789	0	1,789	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	0	9,899	1,077	9,899	1,077	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,450	0	8,450	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,060	0	4,060	0	54.00
60.00	06000	LABORATORY	0	2,767	0	2,767	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	144	0	144	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,736	0	1,736	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,090	0	9,090	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	2,126	0	2,126	0	76.01
76.02	03020	WOUND CARE	0	282	0	282	0	76.02
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	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	2,779	0	2,779	0	90.00
91.00	09100	EMERGENCY	0	4,524	0	4,524	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	56,638	1,077	54,283	1,077	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	872	0	872	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	581	0	581	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	609	0	609	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,625,454	186,323	712,081	262,743	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.690869	173.001857	12.637874	243.958217	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	242,252	18,122	45,104	17,469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.126951	16.826370	0.800497	16.220056	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:

11/19/2021 10:01 am

Cost Center Description		CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	
		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	6,829,612				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	337,508	0	3,610,830		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,400	0	0	764,381	14.00
15.00	01500	PHARMACY	378,123	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	521,185	0	0	2,381,021	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	1,847,725	0	1,847,725	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	706,204	0	706,204	36,827	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,299	0	0	7,566	54.00
60.00	06000	LABORATORY	717,869	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,319	0	0	403	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	56,075	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	237,038	0	0	6,782	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	570	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	482,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	173,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	201,632	0	201,632	16,044	76.01
76.02	03020	WOUND CARE	0	0	0	0	76.02
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	17,865	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	205,145	0	0	1,807	90.00
91.00	09100	EMERGENCY	855,269	0	855,269	20,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,825,791	0	3,610,830	764,381	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,821	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	690,658	0	708,319	214,311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.101127	0.000000	0.196165	0.280372	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,463	0	47,438	30,801	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009439	0.000000	0.013138	0.040295	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & 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	45,379,677					16.00
17.00	01700	SOCIAL SERVICE	0	0				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	2,085,836	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,342,063	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,405,240	0	0	0	0	54.00
60.00	06000	LABORATORY	10,580,319	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,846	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	266,722	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,715,112	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,033,872	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	255,857	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	250,610	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,422,824	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	336,479	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,591,927	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	4,122,348	0	0	0	0	76.01
76.02	03020	WOUND CARE	389,597	0	0	0	0	76.02
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	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	341,212	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,044,813	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,379,677	0	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
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,031,941	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.022740	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,664	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001271	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	16.00	17.00	19.00	20.00	21.00	207.00
						0.000000		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

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			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	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
60.00	06000	LABORATORY	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00	
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	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.00	03950	CARDIAC REHAB	0	0	76.00	
76.01	03951	CHEMOTHERAPY	0	0	76.01	
76.02	03020	WOUND CARE	0	0	76.02	
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	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						
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	
193.01	19301	AFTER CARE PROGRAM	0	0	193.01	
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00	
200.00		Cross Foot Adjustments			200.00	
201.00		Negative Cost Centers			201.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	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	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,627,902		4,627,902	0		0	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,111,613		2,111,613	0		0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,395,875		2,395,875	0		0	54.00
60.00	06000	LABORATORY	2,816,904		2,816,904	0		0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	101,505		101,505	0		0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0		0	62.30
64.00	06400	INTRAVENOUS THERAPY	102,252		102,252	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	593,077	0	593,077	0		0	65.00
66.00	06600	PHYSICAL THERAPY	1,135,287	0	1,135,287	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,004	0	83,004	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	39,879	0	39,879	0		0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	773,593		773,593	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	260,236		260,236	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,071,718		1,071,718	0		0	73.00
76.00	03950	CARDIAC REHAB	0		0	0		0	76.00
76.01	03951	CHEMOTHERAPY	2,814,920		2,814,920	0		0	76.01
76.02	03020	WOUND CARE	152,997		152,997	0		0	76.02
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	4,334,745		4,334,745	0		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0		0	88.01
90.00	09000	CLINIC	549,674		549,674	0		0	90.00
91.00	09100	EMERGENCY	2,635,014		2,635,014	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	345,883		345,883	0		0	92.00
200.00		Subtotal (see instructions)	26,946,078	0	26,946,078	0		0	200.00
201.00		Less Observation Beds	345,883		345,883	0		0	201.00
202.00		Total (see instructions)	26,600,195	0	26,600,195	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,891,129		1,891,129		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	200,833	2,141,230	2,342,063	0.901604	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,749	9,921,491	10,405,240	0.230257	0.000000
60.00	06000	LABORATORY	937,161	9,643,158	10,580,319	0.266240	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,154	142,692	194,846	0.520950	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	336	266,386	266,722	0.383365	0.000000
65.00	06500	RESPIRATORY THERAPY	267,044	1,448,068	1,715,112	0.345795	0.000000
66.00	06600	PHYSICAL THERAPY	405,567	1,628,305	2,033,872	0.558190	0.000000
67.00	06700	OCCUPATIONAL THERAPY	144,749	111,108	255,857	0.324416	0.000000
68.00	06800	SPEECH PATHOLOGY	40,887	209,723	250,610	0.159128	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	751,263	3,671,561	4,422,824	0.174909	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,846	237,633	336,479	0.773409	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	590,526	2,001,401	2,591,927	0.413483	0.000000
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03951	CHEMOTHERAPY	0	4,122,348	4,122,348	0.682844	0.000000
76.02	03020	WOUND CARE	2,218	387,379	389,597	0.392706	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	488,386	3,795,754	4,284,140		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	09000	CLINIC	172	341,040	341,212	1.610946	0.000000
91.00	09100	EMERGENCY	23,023	3,021,790	3,044,813	0.865411	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	194,707	194,707	1.776428	0.000000
200.00		Subtotal (see instructions)	6,378,043	43,285,774	49,663,817		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,378,043	43,285,774	49,663,817		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
76.01	03951	CHEMOTHERAPY	0.000000			76.01
76.02	03020	WOUND CARE	0.000000			76.02
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				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
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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,627,902		4,627,902	0	4,627,902 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,111,613		2,111,613	0	2,111,613 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,395,875		2,395,875	0	2,395,875 54.00
60.00	06000 LABORATORY	2,816,904		2,816,904	0	2,816,904 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	101,505		101,505	0	101,505 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
64.00	06400 INTRAVENOUS THERAPY	102,252		102,252	0	102,252 64.00
65.00	06500 RESPIRATORY THERAPY	593,077	0	593,077	0	593,077 65.00
66.00	06600 PHYSICAL THERAPY	1,135,287	0	1,135,287	0	1,135,287 66.00
67.00	06700 OCCUPATIONAL THERAPY	83,004	0	83,004	0	83,004 67.00
68.00	06800 SPEECH PATHOLOGY	39,879	0	39,879	0	39,879 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	773,593		773,593	0	773,593 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	260,236		260,236	0	260,236 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,071,718		1,071,718	0	1,071,718 73.00
76.00	03950 CARDIAC REHAB	0		0	0	0 76.00
76.01	03951 CHEMOTHERAPY	2,814,920		2,814,920	0	2,814,920 76.01
76.02	03020 WOUND CARE	152,997		152,997	0	152,997 76.02
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	4,334,745		4,334,745	0	4,334,745 88.00
88.01	08801 RURAL HEALTH CLINIC II	0		0	0	0 88.01
90.00	09000 CLINIC	549,674		549,674	0	549,674 90.00
91.00	09100 EMERGENCY	2,635,014		2,635,014	0	2,635,014 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	345,883		345,883	0	345,883 92.00
200.00	Subtotal (see instructions)	26,946,078	0	26,946,078	0	26,946,078 200.00
201.00	Less Observation Beds	345,883		345,883	0	345,883 201.00
202.00	Total (see instructions)	26,600,195	0	26,600,195	0	26,600,195 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,891,129		1,891,129		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	200,833	2,141,230	2,342,063	0.901604	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,749	9,921,491	10,405,240	0.230257	54.00
60.00	06000	LABORATORY	937,161	9,643,158	10,580,319	0.266240	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,154	142,692	194,846	0.520950	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	336	266,386	266,722	0.383365	64.00
65.00	06500	RESPIRATORY THERAPY	267,044	1,448,068	1,715,112	0.345795	65.00
66.00	06600	PHYSICAL THERAPY	405,567	1,628,305	2,033,872	0.558190	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,749	111,108	255,857	0.324416	67.00
68.00	06800	SPEECH PATHOLOGY	40,887	209,723	250,610	0.159128	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	751,263	3,671,561	4,422,824	0.174909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,846	237,633	336,479	0.773409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	590,526	2,001,401	2,591,927	0.413483	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	76.00
76.01	03951	CHEMOTHERAPY	0	4,122,348	4,122,348	0.682844	76.01
76.02	03020	WOUND CARE	2,218	387,379	389,597	0.392706	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	488,386	3,795,754	4,284,140	1.011812	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	88.01
90.00	09000	CLINIC	172	341,040	341,212	1.610946	90.00
91.00	09100	EMERGENCY	23,023	3,021,790	3,044,813	0.865411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	194,707	194,707	1.776428	92.00
200.00		Subtotal (see instructions)	6,378,043	43,285,774	49,663,817		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,378,043	43,285,774	49,663,817		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
76.01	03951	CHEMOTHERAPY	0.000000			76.01
76.02	03020	WOUND CARE	0.000000			76.02
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	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			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
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	236,873	2,342,063	0.101139	97,808	9,892	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,304	10,405,240	0.013196	211,014	2,785	54.00
60.00	06000	LABORATORY	112,227	10,580,319	0.010607	373,428	3,961	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,827	194,846	0.024773	21,525	533	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,927	266,722	0.007225	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,921	1,715,112	0.029690	102,198	3,034	65.00
66.00	06600	PHYSICAL THERAPY	224,739	2,033,872	0.110498	75,491	8,342	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,151	255,857	0.004499	27,378	123	67.00
68.00	06800	SPEECH PATHOLOGY	685	250,610	0.002733	7,849	21	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,831	4,422,824	0.006971	307,221	2,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,606	336,479	0.028549	27,732	792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,101	2,591,927	0.008141	230,240	1,874	73.00
76.00	03950	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	102,227	4,122,348	0.024798	0	0	76.01
76.02	03020	WOUND CARE	8,567	389,597	0.021989	543	12	76.02
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	48,296	4,284,140	0.011273	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
90.00	09000	CLINIC	72,694	341,212	0.213046	0	0	90.00
91.00	09100	EMERGENCY	154,793	3,044,813	0.050838	743	38	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	26,195	194,707	0.134535	0	0	92.00
200.00		Total (lines 50 through 199)	1,244,964	47,772,688		1,483,170	33,549	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03951	CHEMOTHERAPY	0	0	0	0	0 76.01
76.02	03020	WOUND CARE	0	0	0	0	0 76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
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	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: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Title XVIII		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,342,063	0.000000 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,405,240	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	10,580,319	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	194,846	0.000000 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	266,722	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,715,112	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,033,872	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	255,857	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	250,610	0.000000 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,422,824	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	336,479	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,591,927	0.000000 73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0.000000 76.00
76.01	03951	CHEMOTHERAPY	0	0	0	4,122,348	0.000000 76.01
76.02	03020	WOUND CARE	0	0	0	389,597	0.000000 76.02
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	4,284,140	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000 88.01
90.00	09000	CLINIC	0	0	0	341,212	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	3,044,813	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	194,707	0.000000 92.00
200.00		Total (lines 50 through 199)	0	0	0	47,772,688	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	97,808	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	211,014	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	373,428	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	21,525	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	102,198	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	75,491	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	27,378	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,849	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	307,221	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	27,732	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	230,240	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03020	WOUND CARE	0.000000	543	0	0	0	76.02
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	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	743	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,483,170	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/19/2021 10:01 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost		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	0.901604	0	675,866	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230257	0	2,825,162	0	0	54.00	
60.00	06000	LABORATORY	0.266240	0	3,013,117	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.520950	0	92,445	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0.383365	0	130,592	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.345795	0	475,153	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.558190	0	632,009	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.324416	0	24,588	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.159128	0	57,645	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174909	0	1,217,007	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773409	0	88,600	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413483	0	870,972	1,064	0	73.00	
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00	
76.01	03951	CHEMOTHERAPY	0.682844	0	1,869,727	2,458	0	76.01	
76.02	03020	WOUND CARE	0.392706	0	257,122	0	0	76.02	
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						88.01	
90.00	09000	CLINIC	1.610946	0	128,540	0	0	90.00	
91.00	09100	EMERGENCY	0.865411	0	775,773	99,200	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.776428	0	91,798	0	0	92.00	
200.00		Subtotal (see instructions)		0	13,226,116	102,722	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	13,226,116	102,722	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/19/2021 10:01 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	609,363	0					50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	650,513	0					54.00
60.00	06000	LABORATORY	802,212	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,159	0					62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
64.00	06400	INTRAVENOUS THERAPY	50,064	0					64.00
65.00	06500	RESPIRATORY THERAPY	164,306	0					65.00
66.00	06600	PHYSICAL THERAPY	352,781	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	7,977	0					67.00
68.00	06800	SPEECH PATHOLOGY	9,173	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	212,865	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,524	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360,132	440					73.00
76.00	03950	CARDIAC REHAB	0	0					76.00
76.01	03951	CHEMOTHERAPY	1,276,732	1,678					76.01
76.02	03020	WOUND CARE	100,973	0					76.02
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							88.01
90.00	09000	CLINIC	207,071	0					90.00
91.00	09100	EMERGENCY	671,362	85,849					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,073	0					92.00
200.00		Subtotal (see instructions)	5,755,280	87,967					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	5,755,280	87,967					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/19/2021 10:01 am

				Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost		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	0.901604	0	40,300	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230257	0	173,804	0	0	54.00	
60.00	06000	LABORATORY	0.266240	0	119,527	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.520950	0	0	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0.383365	0	1,134	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.345795	0	15,926	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.558190	0	4,069	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.324416	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.159128	0	1,806	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174909	0	92,904	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773409	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413483	0	36,715	0	0	73.00	
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00	
76.01	03951	CHEMOTHERAPY	0.682844	0	0	0	0	76.01	
76.02	03020	WOUND CARE	0.392706	0	0	0	0	76.02	
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						88.01	
90.00	09000	CLINIC	1.610946	0	1,548	0	0	90.00	
91.00	09100	EMERGENCY	0.865411	0	72,131	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.776428	0	5,889	0	0	92.00	
200.00		Subtotal (see instructions)		0	565,753	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	565,753	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/19/2021 10:01 am

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	36,335	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,020	0		54.00
60.00	06000	LABORATORY	31,823	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	435	0		64.00
65.00	06500	RESPIRATORY THERAPY	5,507	0		65.00
66.00	06600	PHYSICAL THERAPY	2,271	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	287	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,250	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,181	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	0	0		76.01
76.02	03020	WOUND CARE	0	0		76.02
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				88.01
90.00	09000	CLINIC	2,494	0		90.00
91.00	09100	EMERGENCY	62,423	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,461	0		92.00
200.00		Subtotal (see instructions)	223,487	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	223,487	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/19/2021 10:01 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,037	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,226	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,077	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		382	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)		382	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		24	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		23	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		598	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)		281	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)		206	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		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,627,902	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		4,286	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)		4,108	25.00
26.00	Total swing-bed cost (see instructions)		1,781,913	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,845,989	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)		2,845,989	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)		2,321.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,388,173	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)		1,388,173	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					506,254	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,894,427	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)					652,302	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					478,200	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,130,502	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)					149	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,321.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					345,883	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/19/2021 10:01 am	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	350,483	4,627,902	0.075733	345,883	26,195	90.00
91.00	Nursing School cost	0	4,627,902	0.000000	345,883	0	91.00
92.00	Allied health cost	0	4,627,902	0.000000	345,883	0	92.00
93.00	All other Medical Education	0	4,627,902	0.000000	345,883	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/19/2021 10:01 am
		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,037	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,226	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,077	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		382	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)		382	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		24	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		23	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		17	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		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,627,902	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		4,286	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)		4,108	25.00
26.00	Total swing-bed cost (see instructions)		1,781,913	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,845,989	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)		2,845,989	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)		2,321.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39,463	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)		39,463	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Title XIX		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)					29,686	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					69,149	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)					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)					149	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,321.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					345,883	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Title XIX		Hospital		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	350,483	4,627,902	0.075733	345,883	26,195	90.00
91.00	Nursing School cost	0	4,627,902	0.000000	345,883	0	91.00
92.00	Allied health cost	0	4,627,902	0.000000	345,883	0	92.00
93.00	All other Medical Education	0	4,627,902	0.000000	345,883	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/19/2021 10:01 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		662,194		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.901604	97,808	88,184	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230257	211,014	48,587	54.00
60.00	06000 LABORATORY	0.266240	373,428	99,421	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.520950	21,525	11,213	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.383365	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.345795	102,198	35,340	65.00
66.00	06600 PHYSICAL THERAPY	0.558190	75,491	42,138	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.324416	27,378	8,882	67.00
68.00	06800 SPEECH PATHOLOGY	0.159128	7,849	1,249	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.174909	307,221	53,736	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.773409	27,732	21,448	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.413483	230,240	95,200	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.682844	0	0	76.01
76.02	03020 WOUND CARE	0.392706	543	213	76.02
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	0.000000		0	88.01
90.00	09000 CLINIC	1.610946	0	0	90.00
91.00	09100 EMERGENCY	0.865411	743	643	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.776428	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,483,170	506,254	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)		1,483,170		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338 Component CCN: 14-Z338	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/19/2021 10:01 am	
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	0.901604	2,739	2,469	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230257	49,782	11,463	54.00
60.00	06000 LABORATORY	0.266240	109,118	29,052	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.520950	1,550	807	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.383365	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.345795	34,485	11,925	65.00
66.00	06600 PHYSICAL THERAPY	0.558190	181,348	101,227	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.324416	64,925	21,063	67.00
68.00	06800 SPEECH PATHOLOGY	0.159128	16,353	2,602	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.174909	90,613	15,849	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.773409	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.413483	78,039	32,268	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.682844	0	0	76.01
76.02	03020 WOUND CARE	0.392706	1,675	658	76.02
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	0.000000		0	88.01
90.00	09000 CLINIC	1.610946	0	0	90.00
91.00	09100 EMERGENCY	0.865411	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.776428	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		630,627	229,383	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)		630,627		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/19/2021 10:01 am	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		16,036		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.901604	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230257	22,767	5,242	54.00
60.00	06000 LABORATORY	0.266240	28,997	7,720	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.520950	2,576	1,342	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.383365	168	64	64.00
65.00	06500 RESPIRATORY THERAPY	0.345795	9,925	3,432	65.00
66.00	06600 PHYSICAL THERAPY	0.558190	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.324416	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.159128	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.174909	13,957	2,441	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.773409	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.413483	10,942	4,524	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.682844	0	0	76.01
76.02	03020 WOUND CARE	0.392706	0	0	76.02
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	1.011812	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0	88.01
90.00	09000 CLINIC	1.610946	0	0	90.00
91.00	09100 EMERGENCY	0.865411	5,686	4,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.776428	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		95,018	29,686	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)		95,018		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/19/2021 10:01 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,843,247
2.00	Medical and other services reimbursed under OPPI (see instructions)			0
3.00	OPPI payments			0
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,843,247
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			0
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
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
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			0
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			5,901,679
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			19,014
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,033,309
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,849,356
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			3,849,356
31.00	Primary payer payments			2,572
32.00	Subtotal (line 30 minus line 31)			3,846,784
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			157,059
35.00	Adjusted reimbursable bad debts (see instructions)			102,088
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			122,576
37.00	Subtotal (see instructions)			3,948,872
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			3,948,872
40.01	Sequestration adjustment (see instructions)			0
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			3,890,298
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			58,574
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/19/2021 10:01 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,676,977		3,865,885	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	02/03/2021	7,901	02/03/2021	49,634	3.01
3.02		05/25/2021	278,121		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	05/25/2021	25,221	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)		286,022		24,413	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)		1,962,999		3,890,298	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		58,574	6.01
6.02	SETTLEMENT TO PROGRAM		162,165		0	6.02
7.00	Total Medicare program liability (see instructions)		1,800,834		3,948,872	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1338

Period:

Worksheet E-1

Component CCN: 14-Z338

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/19/2021 10:01 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,638,072		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	05/25/2021	14,457		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	02/03/2021	242,222		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)		-227,765		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)		1,410,307		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		46,898		0	6.02
7.00	Total Medicare program liability (see instructions)		1,363,409		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/19/2021 10:01 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days 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: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-Z338		Date/Time Prepared: 11/19/2021 10:01 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,141,807	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		231,677	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		487	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,373,484	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,373,484	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,373,484	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		10,075	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,363,409	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,363,409	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,410,307	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		-46,898	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/19/2021 10:01 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,894,427	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)		1,894,427	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,913,371	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)		1,913,371	19.00
20.00	Deductibles (exclude professional component)		131,016	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,782,355	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,782,355	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		28,429	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		18,479	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,977	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,800,834	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)		1,800,834	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		1,962,999	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)		-162,165	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: 14-1338	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/19/2021 10:01 am	
		Title XIX	Hospital	Cost	
			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	69,149			1.00
2.00	Medical and other services			223,487	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	69,149		223,487	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)	69,149		223,487	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	16,036			8.00
9.00	Ancillary service charges	95,018		565,753	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)	111,054		565,753	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)	111,054		565,753	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	41,905		342,266	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)	69,149		223,487	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		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	69,149		223,487	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)	69,149		223,487	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		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)	69,149		223,487	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	69,149		223,487	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)	69,149		223,487	40.00
41.00	Interim payments	69,149		223,487	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		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: 14-1338

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

Worksheet G

Date/Time Prepared:
11/19/2021 10:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,145,504	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	12,616,161	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,320,288	0	0	0	6.00
7.00	Inventory	406,830	0	0	0	7.00
8.00	Prepaid expenses	0	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)	14,848,207	0	0	0	11.00
FIXED ASSETS						
12.00	Land	232,983	0	0	0	12.00
13.00	Land improvements	699,764	0	0	0	13.00
14.00	Accumulated depreciation	-599,600	0	0	0	14.00
15.00	Buildings	21,739,325	0	0	0	15.00
16.00	Accumulated depreciation	-10,843,404	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	1,046,130	0	0	0	19.00
20.00	Accumulated depreciation	-899,356	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	12,577,853	0	0	0	23.00
24.00	Accumulated depreciation	-11,591,185	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	1,687,027	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,049,537	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	35,726,654	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	35,726,654	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,624,398	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,015,352	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,279,335	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,294,687	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,294,687	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	57,329,711				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	57,329,711	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,624,398	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1338

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

Worksheet G-1

Date/Time Prepared:
11/19/2021 10:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		52,635,907		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,693,807				2.00
3.00	Total (sum of line 1 and line 2)		57,329,714		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,329,714		0		11.00
12.00	ROUNDING	3		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,329,711		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1338

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2021 10:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,186,392		1,186,392	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	636,065		636,065	5.00
6.00	Swing bed - NF	39,130		39,130	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)	1,861,587		1,861,587	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)	1,861,587		1,861,587	17.00
18.00	Ancillary services	3,982,948	0	3,982,948	18.00
19.00	Outpatient services	0	37,005,231	37,005,231	19.00
20.00	RURAL HEALTH CLINIC	503,433	6,317,909	6,821,342	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	30,863	3,688,711	3,719,574	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,378,831	47,011,851	53,390,682	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,960,578		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,960,578		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1338

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

Worksheet G-3

Date/Time Prepared:
11/19/2021 10:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,390,682	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,944,704	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,445,978	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,960,578	4.00
5.00	Net income from service to patients (line 3 minus line 4)	485,400	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	708,377	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	96,623	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	47,600	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	71,487	17.00
18.00	Revenue from sale of medical records and abstracts	12,496	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B RETAILPHARMACY NET REV	1,645,996	24.00
24.01	OTHER OPER REV - BUSI UNIT 5000	35,499	24.01
24.02	OTHER NON OP REV	206,480	24.02
24.50	COVID-19 PHE Funding	1,383,849	24.50
25.00	Total other income (sum of lines 6-24)	4,208,407	25.00
26.00	Total (line 5 plus line 25)	4,693,807	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,693,807	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 10:01 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,377,247	427,619	1,804,866	-129,575	1,675,291
2.00	Physician Assistant	190,203	58,600	248,803	-179	248,624
3.00	Nurse Practitioner	115,673	35,638	151,311	0	151,311
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	566,183	174,436	740,619	0	740,619
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	55,221	17,013	72,234	0	72,234
9.00	Other Facility Health Care Staff Costs	179,135	55,190	234,325	0	234,325
10.00	Subtotal (sum of lines 1 through 9)	2,483,662	768,496	3,252,158	-129,754	3,122,404
11.00	Physician Services Under Agreement	0	1,000,532	1,000,532	0	1,000,532
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	1,000,532	1,000,532	0	1,000,532
15.00	Medical Supplies	0	23,222	23,222	0	23,222
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	64,277	64,277	-64,277	0
19.00	Other Health Care Costs	0	307,315	307,315	-39,834	267,481
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	394,814	394,814	-104,111	290,703
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,483,662	2,163,842	4,647,504	-233,865	4,413,639
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	1,962	1,962
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,962	1,962
FACILITY OVERHEAD						
29.00	Facility Costs	0	148,677	148,677	0	148,677
30.00	Administrative Costs	433,280	222,810	656,090	-478,749	177,341
31.00	Total Facility Overhead (sum of lines 29 and 30)	433,280	371,487	804,767	-478,749	326,018
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,916,942	2,535,329	5,452,271	-710,652	4,741,619

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 10:01 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,675,291	1.00
2.00	Physician Assistant	0	248,624	2.00
3.00	Nurse Practitioner	0	151,311	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	740,619	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	72,234	8.00
9.00	Other Facility Health Care Staff Costs	0	234,325	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,122,404	10.00
11.00	Physician Services Under Agreement	-1,000,532	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)	-1,000,532	0	14.00
15.00	Medical Supplies	0	23,222	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-86,323	181,158	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-86,323	204,380	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,086,855	3,326,784	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	1,962	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,962	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	148,677	29.00
30.00	Administrative Costs	-989	176,352	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-989	325,029	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,087,844	3,653,775	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1338

Period:

Worksheet M-2

Component CCN: 14-8543

From 07/01/2020
To 06/30/2021Date/Time Prepared:
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				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.50	13,220	3,780	13,230		1.00
2.00	Physician Assistant	1.42	2,675	1,890	2,684		2.00
3.00	Nurse Practitioner	0.89	2,013	2,100	1,869		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.81	17,908		17,783	17,908	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)	5.81	17,908			17,908	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)					3,326,784	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,962	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,328,746	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999411	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					325,029	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					680,970	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,005,999	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,005,999	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,005,406	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,332,190	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/19/2021 10:01 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,332,190	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			173,558	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,158,632	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,908	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)			17,908	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			232.22	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	202.53	8.00
9.00	Rate for Program covered visits (see instructions)	232.22	232.22	202.53	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,618	1,177	1,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	607,952	273,323	262,479	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,143,754		16.00
16.01	Total program charges (see instructions)(from contractor's records)		994,910		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		792		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		910		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.)		827,364		16.04
16.05	Total program cost (see instructions)	0	828,274		16.05
17.00	Primary payer amounts		73		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		108,639		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		177,096		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		828,201		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		52,217		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		880,418		22.00
23.00	Allowable bad debts (see instructions)		31,197		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		20,278		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,941		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)		900,696		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		631,842		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)		268,854		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: 14-1338

Period:

Worksheet M-4

Component CCN: 14-8543

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/19/2021 10:01 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,122,404	3,122,404	3,122,404	3,122,404	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003600	0.018315	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	11,241	57,187	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	26,618	38,233	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	37,859	95,420	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,326,784	3,326,784	3,326,784	3,326,784	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,005,406	1,005,406	1,005,406	1,005,406	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011380	0.028682	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,442	28,837	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49,301	124,257	0	0	10.00
11.00	Total number of injections/infusions (from your records)	261	1,328	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	188.89	93.57	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	56	445	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)	10,578	41,639	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)		173,558			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)		52,217			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/19/2021 10:01 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		677,577	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		05/25/2021	13,629		3.50
3.51		05/25/2021	32,106		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)		-45,735		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		631,842		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		268,854		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		900,696		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00