

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/25/2022 11:30 am
--	-----------------------	---------------------------------------	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/25/2022	Time: 11:30 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION COUNTY HOSPITAL DISTRICT (14-1342) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	458,668	756,919	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	145,463	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		8,051		0	10.00
200.00 Total	0	604,131	764,970	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: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/25/2022 11:30 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 517 NORTH MAIN STREET			PO Box:		Date Certified		Payment System (P, T, O, or N)	
2.00	City: ANNA			State: IL		Zip Code: 62906		County: UNION	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				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			UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N O P
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	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			UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N O N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)						4		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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/25/2022 11:30 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		25.00
					Urban/Rural St	Date of Geogra	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 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
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/25/2022 11:30 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)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/25/2022 11:30 am

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

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/25/2022 11:30 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	75,300	6,862	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/25/2022 11:30 am	
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: QUORUM HEALTH CORPORATION		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280		141.00		
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100				142.00		
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							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	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			Y	Y	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	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	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/25/2022 11:30 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/22/2022	Y	03/22/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/25/2022 11:30 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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.	CHRIS	WHITE		41.00
42.00	Enter the employer/company name of the cost report preparer	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3792	CWHITE02@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/25/2022 11:30 am

		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.	VICE PRESIDENT REIMBURSEMENT	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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	30,144.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	30,144.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	30,144.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/25/2022 11:30 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)	893	22	1,256			1.00
2.00	HMO and other (see instructions)	2	129				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	380	0	723			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	69			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,273	22	2,048			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)	1,273	22	2,048	0.00	104.50	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			0	0.00	14.99	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	600	0	5,977	0.00	6.95	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	126.44	27.00
28.00	Observation Bed Days		0	243			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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/25/2022 11:30 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	215	8	372	1.00
2.00 HMO and other (see instructions)			1	46		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	215	8	372	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	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		UNION COUNTY HOSPITAL DISTRICT		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1342 Component CCN: 14-3975		Period: From 01/01/2021 To 12/31/2021 Worksheet S-8 Date/Time Prepared: 5/25/2022 11:30 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	517 NORTH MAIN STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL 62906	2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	UNION		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342

Period:

Worksheet S-8

Component CCN: 14-3975

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

Date/Time Prepared:

5/25/2022 11:30 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00	09:00	16:50		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/25/2022 11:30 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)		0.278902		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,832,560		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,279,193		5.00
6.00	Medicaid charges		20,610,396		6.00
7.00	Medicaid cost (line 1 times line 6)		5,748,281		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		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)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	943,492	0	943,492	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	263,142	0	263,142	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	263,142	0	263,142	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,192,889		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		770,681		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,185,662		27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,007,227		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		974,801		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,237,943		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,237,943		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		141,453	141,453	125,738	267,191	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,270,887	1,270,887	0	1,270,887	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	93,386	25,762	119,148	1,272,837	1,391,985	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,325,100	1,325,100	62,813	1,387,913	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,047,143	6,612,002	7,659,145	-1,591,886	6,067,259	5.02
7.00	00700	OPERATION OF PLANT	266,849	654,450	921,299	9,105	930,404	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,620	990	32,610	0	32,610	8.00
9.00	00900	HOUSEKEEPING	222,127	89,296	311,423	29,386	340,809	9.00
10.00	01000	DIETARY	0	530,778	530,778	0	530,778	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	905,128	123,529	1,028,657	-429,687	598,970	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,447	145,098	237,545	-111,819	125,726	14.00
15.00	01500	PHARMACY	319,865	697,228	1,017,093	-589,102	427,991	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,190	8,190	0	8,190	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	794,117	969,009	1,763,126	507,239	2,270,365	30.00
46.00	04600	OTHER LONG TERM CARE	752,614	134,222	886,836	-38,491	848,345	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	275,922	160,966	436,888	71,723	508,611	50.00
51.00	05100	RECOVERY ROOM	64,159	7,564	71,723	-71,723	0	51.00
53.00	05300	ANESTHESIOLOGY	0	309,074	309,074	0	309,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,690	146,990	497,680	447,314	944,994	54.00
54.01	05401	ULTRASOUND	92,985	20,799	113,784	-113,784	0	54.01
56.00	05600	RADIOISOTOPE	0	68,103	68,103	-68,103	0	56.00
57.00	05700	CT SCAN	52,670	69,715	122,385	-122,385	0	57.00
58.00	05800	MRI	49,156	93,886	143,042	-143,042	0	58.00
60.00	06000	LABORATORY	423,753	597,329	1,021,082	0	1,021,082	60.00
65.00	06500	RESPIRATORY THERAPY	81,058	40,317	121,375	-32,039	89,336	65.00
66.00	06600	PHYSICAL THERAPY	234,060	37,668	271,728	0	271,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	230,081	17,725	247,806	0	247,806	67.00
68.00	06800	SPEECH PATHOLOGY	91,129	6,898	98,027	0	98,027	68.00
69.00	06900	ELECTROCARDIOLOGY	72,937	38,563	111,500	0	111,500	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	136,359	136,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,499	7,499	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	589,102	589,102	73.00
76.00	03610	SLEEP LAB	0	97,211	97,211	0	97,211	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	497,458	497,458	0	497,458	76.01
76.03	03950	WOUND CARE	18,051	33,685	51,736	0	51,736	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	644,239	539,059	1,183,298	-62,813	1,120,485	88.00
91.00	09100	EMERGENCY	946,290	1,272,250	2,218,540	0	2,218,540	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)	8,152,476	16,783,254	24,935,730	-115,759	24,819,971	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	22,871	22,871	774	23,645	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	114,985	114,985	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	220	220	0	220	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,152,476	16,806,345	24,958,821	0	24,958,821	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
5/25/2022 11:30 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	622,611	889,802	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-95,631	1,175,256	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,391,985	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,387,913	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,730,701	4,336,558	5.02
7.00	00700	OPERATION OF PLANT	-1,198	929,206	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,610	8.00
9.00	00900	HOUSEKEEPING	0	340,809	9.00
10.00	01000	DIETARY	0	530,778	10.00
11.00	01100	CAFETERIA	-19,085	-19,085	11.00
13.00	01300	NURSING ADMINISTRATION	0	598,970	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	125,726	14.00
15.00	01500	PHARMACY	0	427,991	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-298	7,892	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-825,039	1,445,326	30.00
46.00	04600	OTHER LONG TERM CARE	0	848,345	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	508,611	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	309,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	944,994	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	1,021,082	60.00
65.00	06500	RESPIRATORY THERAPY	0	89,336	65.00
66.00	06600	PHYSICAL THERAPY	0	271,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,806	67.00
68.00	06800	SPEECH PATHOLOGY	0	98,027	68.00
69.00	06900	ELECTROCARDIOLOGY	0	111,500	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	136,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,499	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	589,102	73.00
76.00	03610	SLEEP LAB	0	97,211	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	497,458	76.01
76.03	03950	WOUND CARE	0	51,736	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-344,056	776,429	88.00
91.00	09100	EMERGENCY	-314,691	1,903,849	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)	-2,708,088	22,111,883	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,645	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	114,985	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	220	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,708,088	22,250,733	200.00

RECLASSIFICATIONS

Provider CCN: 14-1342

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

Worksheet A-6

Date/Time Prepared:
5/25/2022 11:30 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,272,837	1.00	
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	774	2.00	
	0		0	1,273,611		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	32,039	1.00	
	0		0	32,039		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,036	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	83,702	2.00	
	0		0	125,738		
	E - MARKETING DEPT					
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	65,783	49,202	1.00	
	0		65,783	49,202		
	F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	104,320	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,499	2.00	
	0		0	111,819		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	589,102	1.00	
	0		0	589,102		
	J - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	194,811	252,503	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		194,811	252,503		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	64,159	7,564	1.00	
	0		64,159	7,564		
	M - RHC SALARY TO ADMIN					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	62,813	0	1.00	
	0		62,813	0		
	N - INFECTION CONTROL					
1.00	NURSING ADMINISTRATION	13.00	65,327	12,225	1.00	
	0		65,327	12,225		
	O - RECLASS COSTS TO HSKP AND MAINT					
1.00	OPERATION OF PLANT	7.00	9,105	0	1.00	
2.00	HOUSEKEEPING	9.00	29,386	0	2.00	
	0		38,491	0		
	P - HOUSE SUPERVISORS					
1.00	ADULTS & PEDIATRICS	30.00	507,239	0	1.00	
	TOTALS		507,239	0		
500.00	Grand Total: Increases		998,623	2,453,803	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1342

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

Worksheet A-6

Date/Time Prepared:
5/25/2022 11:30 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,273,611	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	1,273,611		
B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	32,039	0	1.00
	0		0	32,039		
D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	125,738	12	1.00
2.00		0.00	0	0	13	2.00
	0		0	125,738		
E - MARKETING DEPT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	65,783	49,202	0	1.00
	0		65,783	49,202		
F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	111,819	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	111,819		
G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	589,102	0	1.00
	0		0	589,102		
J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	92,985	20,799	0	1.00
2.00	RADIOISOTOPE	56.00	0	68,103	0	2.00
3.00	CT SCAN	57.00	52,670	69,715	0	3.00
4.00	MRI	58.00	49,156	93,886	0	4.00
	0		194,811	252,503		
K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	64,159	7,564	0	1.00
	0		64,159	7,564		
M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	62,813	0	0	1.00
	0		62,813	0		
N - INFECTION CONTROL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	65,327	12,225	0	1.00
	0		65,327	12,225		
O - RECLASS COSTS TO HSKP AND MAINT						
1.00	OTHER LONG TERM CARE	46.00	38,491	0	0	1.00
2.00		0.00	0	0	0	2.00
	0		38,491	0		
P - HOUSE SUPERVISORS						
1.00	NURSING ADMINISTRATION	13.00	507,239	0	0	1.00
	TOTALS		507,239	0		
500.00	Grand Total: Decreases		998,623	2,453,803		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/25/2022 11:30 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	0	0	0	0	0	1.00	
2.00	Land Improvements	47,473	0	0	0	0	2.00	
3.00	Buildings and Fixtures	6,999,202	0	0	0	0	3.00	
4.00	Building Improvements	14,304,820	1,687,304	0	1,687,304	304,158	4.00	
5.00	Fixed Equipment	2,537,878	132,527	0	132,527	0	5.00	
6.00	Movable Equipment	7,884,203	1,571,889	0	1,571,889	858,023	6.00	
7.00	HIT designated Assets	3,254,127	0	0	0	67,937	7.00	
8.00	Subtotal (sum of lines 1-7)	35,027,703	3,391,720	0	3,391,720	1,230,118	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	35,027,703	3,391,720	0	3,391,720	1,230,118	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	47,473	0				2.00	
3.00	Buildings and Fixtures	6,999,202	0				3.00	
4.00	Building Improvements	15,687,966	0				4.00	
5.00	Fixed Equipment	2,670,405	0				5.00	
6.00	Movable Equipment	8,598,069	0				6.00	
7.00	HIT designated Assets	3,186,190	0				7.00	
8.00	Subtotal (sum of lines 1-7)	37,189,305	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	37,189,305	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/25/2022 11:30 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	141,453	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,270,887	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,412,340	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	141,453				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,270,887				2.00
3.00	Total (sum of lines 1-2)	0	1,412,340				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/25/2022 11:30 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	25,405,046	0	25,405,046	0.683128	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,784,259	0	11,784,259	0.316872	0	2.00
3.00	Total (sum of lines 1-2)	37,189,305	0	37,189,305	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	764,064	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,175,256	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,939,320	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	42,036	83,702	0	889,802	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,175,256	2.00
3.00	Total (sum of lines 1-2)	0	42,036	83,702	0	2,065,058	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,343	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,636	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,139,730			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	199,107			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-19,085	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-298	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	530,906	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-198,087	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-5,395	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.02	IL PROVIDER TAX	B	-1,209,906	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
34.00	LOBBY EXPENSE	A	-27,000	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.00
34.01	CHARITABLE CONTRIBUTIONS	A	-1,769	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.01
35.00	MIS AMORTIZATION ADJUSTMENT	A	-341,404	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-1,076	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-1,198	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-91,861	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	IL PROVIDER TAX FOR NH	A	0	OTHER LONG TERM CARE	46.00	0	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-11,320	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	40.00
41.00	MISCELLANEOUS INCOME	B	-40,937	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
41.01	ADMIN SERVICES ALLOCATED TO RHC	A	-344,056	RURAL HEALTH CLINIC	88.00	0	41.01
41.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.02
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,708,088				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2022 11:30 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	91,705	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	105,168	0
3.00		5.02	OTHER ADMINISTRATIVE AND GEN	ALLOCATED COSTS	1,009,272	769,537
3.01		5.02	OTHER ADMINISTRATIVE AND GEN	DIRECT COSTS	7,785	0
4.00		5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	82,162	327,448
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				1,296,092	1,096,985

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2022 11:30 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	91,705	9		1.00
2.00	105,168	9		2.00
3.00	239,735	0		3.00
3.01	7,785	0		3.01
4.00	-245,286	0		4.00
5.00	199,107			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1342

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

Worksheet A-8-2

Date/Time Prepared:
5/25/2022 11:30 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	825,039	825,039	0	0	0	1.00
2.00	91.00	EMERGENCY	1,043,797	314,691	729,106	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,868,836	1,139,730	729,106			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	825,039		1.00
2.00	91.00	EMERGENCY	0	0	0	314,691		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,139,730		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	889,802	889,802			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,175,256		1,175,256		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,391,985	6,668	8,807	1,407,460	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,387,913	10,945	14,457	10,970	1,424,285
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	4,336,558	71,243	94,098	159,979	0
7.00	00700	OPERATION OF PLANT	929,206	237,155	313,239	48,193	0
8.00	00800	LAUNDRY & LINEN SERVICE	32,610	14,662	19,365	5,522	0
9.00	00900	HOUSEKEEPING	340,809	11,653	15,391	43,925	0
10.00	01000	DIETARY	530,778	46,148	60,953	0	0
11.00	01100	CAFETERIA	-19,085	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	598,970	7,376	9,742	80,897	0
14.00	01400	CENTRAL SERVICES & SUPPLY	125,726	17,638	23,296	16,145	0
15.00	01500	PHARMACY	427,991	10,815	14,285	55,862	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,892	9,254	12,223	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,445,326	59,078	78,030	227,270	61,657
46.00	04600	OTHER LONG TERM CARE	848,345	55,793	73,691	124,717	11,124
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	508,611	34,414	45,454	59,393	66,991
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	309,074	0	0	0	15,438
54.00	05400	RADIOLOGY-DIAGNOSTIC	944,994	48,767	64,411	95,268	510,282
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	1,021,082	16,947	22,383	74,005	260,616
65.00	06500	RESPIRATORY THERAPY	89,336	6,367	8,410	14,156	7,686
66.00	06600	PHYSICAL THERAPY	271,728	53,873	71,156	40,877	50,366
67.00	06700	OCCUPATIONAL THERAPY	247,806	4,497	5,940	40,182	13,498
68.00	06800	SPEECH PATHOLOGY	98,027	2,147	2,836	15,915	4,612
69.00	06900	ELECTROCARDIOLOGY	111,500	6,018	7,948	12,738	26,537
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,359	0	0	0	11,371
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,499	0	0	0	1,758
73.00	07300	DRUGS CHARGED TO PATIENTS	589,102	0	0	0	106,514
76.00	03610	SLEEP LAB	97,211	4,676	6,176	0	4,476
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	497,458	9,945	13,136	0	12,858
76.03	03950	WOUND CARE	51,736	5,400	7,132	3,152	2,025
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	776,429	28,242	37,302	101,542	19,223
91.00	09100	EMERGENCY	1,903,849	40,911	54,036	165,263	237,253
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,111,883	820,632	1,083,897	1,395,971	1,424,285
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,473	5,907	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,645	49,222	65,013	0	0
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	114,985	3,350	4,425	11,489	0
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	220	0	0	0	0
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0
194.04	07954	LEASED TO SPECIALTY CLINICS	0	12,125	16,014	0	0
194.05	07955	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	22,250,733	889,802	1,175,256	1,407,460	1,424,285

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	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
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	4,661,878	4,661,878				5.02
7.00	00700	OPERATION OF PLANT	1,527,793	404,498	1,932,291			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,159	19,105	50,251	141,515		8.00
9.00	00900	HOUSEKEEPING	411,778	109,022	39,938	4,223	564,961	9.00
10.00	01000	DIETARY	637,879	168,885	158,165	747	48,508	10.00
11.00	01100	CAFETERIA	-19,085	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	696,985	184,534	25,279	0	7,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	182,805	48,399	60,451	0	18,540	14.00
15.00	01500	PHARMACY	508,953	134,750	37,068	0	11,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,369	7,776	31,717	0	9,727	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,871,361	495,462	202,477	35,078	62,098	30.00
46.00	04600	OTHER LONG TERM CARE	1,113,670	294,855	191,220	57,171	58,646	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	714,863	189,267	117,948	6,100	36,174	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	324,512	85,918	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,663,722	440,487	167,140	7,831	51,261	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,395,033	369,349	58,082	0	17,813	60.00
65.00	06500	RESPIRATORY THERAPY	125,955	33,348	21,823	0	6,693	65.00
66.00	06600	PHYSICAL THERAPY	488,000	129,203	184,642	7,831	56,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	311,923	82,585	15,412	0	4,727	67.00
68.00	06800	SPEECH PATHOLOGY	123,537	32,708	7,358	0	2,257	68.00
69.00	06900	ELECTROCARDIOLOGY	164,741	43,617	20,624	0	6,325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,730	39,113	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,257	2,451	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	695,616	184,171	0	0	0	73.00
76.00	03610	SLEEP LAB	112,539	29,796	16,026	0	4,915	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	533,397	141,222	34,086	0	10,454	76.01
76.03	03950	WOUND CARE	69,445	18,386	18,506	0	5,676	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	962,738	254,895	96,794	1,313	29,686	88.00
91.00	09100	EMERGENCY	2,401,312	635,771	140,217	21,221	43,004	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)		21,939,865	4,579,573	1,695,224	141,515	492,254	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,380	2,748	15,329	0	4,701	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,880	36,505	168,700	0	51,739	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	134,249	35,544	11,483	0	3,522	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	220	58	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	28,139	7,450	41,555	0	12,745	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,250,733	4,661,878	1,932,291	141,515	564,961	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	1,014,184					10.00
11.00	01100	CAFETERIA	254,349	235,264				11.00
13.00	01300	NURSING ADMINISTRATION	0	15,806	930,357			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,886	0	315,081		14.00
15.00	01500	PHARMACY	0	6,955	0	6,148	705,242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	238,721	40,959	441,593	21,193	0	30.00
46.00	04600	OTHER LONG TERM CARE	482,627	37,370	0	7,944	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,687	115,401	42,931	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,309	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,013	0	10,974	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,501	0	84,484	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,540	27,506	1,136	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,374	0	1,691	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,432	0	77	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,269	0	135	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,493	24,750	13	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	82,905	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	286	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	705,242	73.00
76.00	03610	SLEEP LAB	0	0	0	1,297	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23,918	0	0	120	0	76.01
76.03	03950	WOUND CARE	0	1,122	0	1,428	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	17,326	0	7,178	0	88.00
91.00	09100	EMERGENCY	14,569	31,262	321,107	43,832	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)	1,014,184	232,995	930,357	315,081	705,242	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	2,269	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,014,184	235,264	930,357	315,081	705,242	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,589				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,401	3,412,343	0	3,412,343	30.00
46.00	04600	OTHER LONG TERM CARE	614	2,244,117	0	2,244,117	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,695	1,240,066	0	1,240,066	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	852	412,591	0	412,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,172	2,391,600	0	2,391,600	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	14,376	1,956,638	0	1,956,638	60.00
65.00	06500	RESPIRATORY THERAPY	424	220,425	0	220,425	65.00
66.00	06600	PHYSICAL THERAPY	2,778	880,148	0	880,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	745	421,901	0	421,901	67.00
68.00	06800	SPEECH PATHOLOGY	254	168,518	0	168,518	68.00
69.00	06900	ELECTROCARDIOLOGY	1,464	264,027	0	264,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	627	270,375	0	270,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97	12,091	0	12,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,875	1,590,904	0	1,590,904	73.00
76.00	03610	SLEEP LAB	247	164,820	0	164,820	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	709	743,906	0	743,906	76.01
76.03	03950	WOUND CARE	112	114,675	0	114,675	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,060	1,370,990	0	1,370,990	88.00
91.00	09100	EMERGENCY	13,087	3,665,382	0	3,665,382	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)	78,589	21,545,517	0	21,545,517	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,158	0	33,158	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	394,824	0	394,824	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	187,067	0	187,067	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	278	0	278	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	89,889	0	89,889	194.04
194.05	07955	VACANT SPACE	0	0	0	0	194.05
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	78,589	22,250,733	0	22,250,733	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,668	8,807	15,475	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	10,945	14,457	25,402	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	71,243	94,098	165,341	5.02
7.00	00700	OPERATION OF PLANT	0	237,155	313,239	550,394	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,662	19,365	34,027	8.00
9.00	00900	HOUSEKEEPING	0	11,653	15,391	27,044	9.00
10.00	01000	DIETARY	0	46,148	60,953	107,101	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,376	9,742	17,118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,638	23,296	40,934	14.00
15.00	01500	PHARMACY	0	10,815	14,285	25,100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,254	12,223	21,477	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	59,078	78,030	137,108	30.00
46.00	04600	OTHER LONG TERM CARE	0	55,793	73,691	129,484	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	34,414	45,454	79,868	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,767	64,411	113,178	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	16,947	22,383	39,330	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,367	8,410	14,777	65.00
66.00	06600	PHYSICAL THERAPY	0	53,873	71,156	125,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,497	5,940	10,437	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,147	2,836	4,983	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,018	7,948	13,966	69.00
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	03610	SLEEP LAB	0	4,676	6,176	10,852	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	9,945	13,136	23,081	76.01
76.03	03950	WOUND CARE	0	5,400	7,132	12,532	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	28,242	37,302	65,544	88.00
91.00	09100	EMERGENCY	0	40,911	54,036	94,947	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	820,632	1,083,897	1,904,529	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,473	5,907	10,380	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,222	65,013	114,235	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	3,350	4,425	7,775	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	12,125	16,014	28,139	194.04
194.05	07955	VACANT SPACE	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	889,802	1,175,256	2,065,058	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	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
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	25,523					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	167,100				5.02
7.00	00700	OPERATION OF PLANT	0	14,499	565,423			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	685	14,704	49,477		8.00
9.00	00900	HOUSEKEEPING	0	3,908	11,687	1,477	44,599	9.00
10.00	01000	DIETARY	0	6,053	46,282	261	3,829	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,614	7,397	0	612	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,735	17,689	0	1,464	14.00
15.00	01500	PHARMACY	0	4,830	10,847	0	897	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	279	9,281	0	768	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,104	17,759	59,248	12,264	4,904	30.00
46.00	04600	OTHER LONG TERM CARE	199	10,569	55,954	19,988	4,630	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,199	6,784	34,514	2,133	2,856	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	276	3,080	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,163	15,789	48,908	2,738	4,047	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,665	13,239	16,996	0	1,406	60.00
65.00	06500	RESPIRATORY THERAPY	138	1,195	6,386	0	528	65.00
66.00	06600	PHYSICAL THERAPY	901	4,631	54,030	2,738	4,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	242	2,960	4,510	0	373	67.00
68.00	06800	SPEECH PATHOLOGY	83	1,172	2,153	0	178	68.00
69.00	06900	ELECTROCARDIOLOGY	475	1,563	6,035	0	499	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204	1,402	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31	88	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,906	6,601	0	0	0	73.00
76.00	03610	SLEEP LAB	80	1,068	4,689	0	388	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	230	5,062	9,974	0	825	76.01
76.03	03950	WOUND CARE	36	659	5,415	0	448	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	344	9,136	28,324	459	2,343	88.00
91.00	09100	EMERGENCY	4,247	22,790	41,030	7,419	3,395	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)	25,523	164,150	496,053	49,477	38,860	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99	4,485	0	371	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,308	49,365	0	4,084	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	1,274	3,360	0	278	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	267	12,160	0	1,006	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	25,523	167,100	565,423	49,477	44,599	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	163,526					10.00
11.00	01100	CAFETERIA	41,011	37,934				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,548	35,178			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	788	0	62,787		14.00
15.00	01500	PHARMACY	0	1,121	0	1,225	44,634	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,491	6,604	16,696	4,223	0	30.00
46.00	04600	OTHER LONG TERM CARE	77,818	6,026	0	1,583	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,207	4,364	8,555	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	261	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,549	0	2,187	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,822	0	16,835	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	571	1,040	226	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,511	0	337	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,037	0	15	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	366	0	27	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	402	936	3	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,521	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	57	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	44,634	73.00
76.00	03610	SLEEP LAB	0	0	0	258	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,857	0	0	24	0	76.01
76.03	03950	WOUND CARE	0	181	0	285	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,794	0	1,430	0	88.00
91.00	09100	EMERGENCY	2,349	5,041	12,142	8,735	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)	163,526	37,568	35,178	62,787	44,634	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	366	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	3,077	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,526	41,011	35,178	62,787	44,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,805				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,378	302,279	0	302,279	30.00
46.00	04600	OTHER LONG TERM CARE	249	307,871	0	307,871	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,497	144,630	0	144,630	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	345	3,962	0	3,962	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,379	211,985	0	211,985	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	5,824	101,931	0	101,931	60.00
65.00	06500	RESPIRATORY THERAPY	172	25,189	0	25,189	65.00
66.00	06600	PHYSICAL THERAPY	1,126	195,222	0	195,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	302	20,318	0	20,318	67.00
68.00	06800	SPEECH PATHOLOGY	103	9,240	0	9,240	68.00
69.00	06900	ELECTROCARDIOLOGY	593	24,612	0	24,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	254	18,381	0	18,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39	215	0	215	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,380	55,521	0	55,521	73.00
76.00	03610	SLEEP LAB	100	17,435	0	17,435	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	287	43,340	0	43,340	76.01
76.03	03950	WOUND CARE	45	19,636	0	19,636	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	430	111,920	0	111,920	88.00
91.00	09100	EMERGENCY	5,302	209,214	0	209,214	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)	31,805	1,822,901	0	1,822,901	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,335	0	15,335	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	168,992	0	168,992	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	13,179	0	13,179	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2	0	2	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	41,572	0	41,572	194.04
194.05	07955	VACANT SPACE	0	0	0	0	194.05
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	3,077	0	3,077	201.00
202.00		TOTAL (sum lines 118 through 201)	31,805	2,065,058	0	2,065,058	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1342

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

Worksheet B-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00				
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	109,422					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		109,422				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	820	820	8,059,090			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,346	1,346	62,813	77,251,164		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	8,761	8,761	916,033	0	-4,661,878	5.02
7.00	00700	OPERATION OF PLANT	29,164	29,164	275,954	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,803	1,803	31,620	0	0	8.00
9.00	00900	HOUSEKEEPING	1,433	1,433	251,513	0	0	9.00
10.00	01000	DIETARY	5,675	5,675	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	19,085	11.00
13.00	01300	NURSING ADMINISTRATION	907	907	463,216	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,169	2,169	92,447	0	0	14.00
15.00	01500	PHARMACY	1,330	1,330	319,865	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,138	1,138	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,265	7,265	1,301,356	3,344,221	0	30.00
46.00	04600	OTHER LONG TERM CARE	6,861	6,861	714,123	603,340	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,232	4,232	340,081	3,633,500	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	837,316	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,997	5,997	545,501	27,676,809	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,084	2,084	423,753	14,135,473	0	60.00
65.00	06500	RESPIRATORY THERAPY	783	783	81,058	416,874	0	65.00
66.00	06600	PHYSICAL THERAPY	6,625	6,625	234,060	2,731,809	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	553	553	230,081	732,094	0	67.00
68.00	06800	SPEECH PATHOLOGY	264	264	91,129	250,125	0	68.00
69.00	06900	ELECTROCARDIOLOGY	740	740	72,937	1,439,353	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	616,727	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95,360	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,777,208	0	73.00
76.00	03610	SLEEP LAB	575	575	0	242,766	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,223	1,223	0	697,413	0	76.01
76.03	03950	WOUND CARE	664	664	18,051	109,819	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,473	3,473	581,426	1,042,658	0	88.00
91.00	09100	EMERGENCY	5,031	5,031	946,290	12,868,299	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)	100,916	100,916	7,993,307	77,251,164	-4,642,793	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	550	550	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,053	6,053	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	412	412	65,783	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,491	1,491	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	889,802	1,175,256	1,407,460	1,424,285		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.131838	10.740582	0.174643	0.018437		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,475	25,523		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001920	0.000330		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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAU NDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	17,607,940				5.02
7.00	00700	OPERATION OF PLANT	1,527,793	69,331			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,159	1,803	51,502		8.00
9.00	00900	HOUSEKEEPING	411,778	1,433	1,537	66,095	9.00
10.00	01000	DIETARY	637,879	5,675	272	5,675	28,749 10.00
11.00	01100	CAFETERIA	0	0	0	0	7,210 11.00
13.00	01300	NURSING ADMINISTRATION	696,985	907	0	907	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	182,805	2,169	0	2,169	0 14.00
15.00	01500	PHARMACY	508,953	1,330	0	1,330	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,369	1,138	0	1,138	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,871,361	7,265	12,766	7,265	6,767 30.00
46.00	04600	OTHER LONG TERM CARE	1,113,670	6,861	20,806	6,861	13,681 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	714,863	4,232	2,220	4,232	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	324,512	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,663,722	5,997	2,850	5,997	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	1,395,033	2,084	0	2,084	0 60.00
65.00	06500	RESPIRATORY THERAPY	125,955	783	0	783	0 65.00
66.00	06600	PHYSICAL THERAPY	488,000	6,625	2,850	6,625	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	311,923	553	0	553	0 67.00
68.00	06800	SPEECH PATHOLOGY	123,537	264	0	264	0 68.00
69.00	06900	ELECTROCARDIOLOGY	164,741	740	0	740	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,730	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,257	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	695,616	0	0	0	0 73.00
76.00	03610	SLEEP LAB	112,539	575	0	575	0 76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	533,397	1,223	0	1,223	678 76.01
76.03	03950	WOUND CARE	69,445	664	0	664	0 76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	962,738	3,473	478	3,473	0 88.00
91.00	09100	EMERGENCY	2,401,312	5,031	7,723	5,031	413 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)	17,297,072	60,825	51,502	57,589	28,749 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,380	550	0	550	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,880	6,053	0	6,053	0 192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	134,249	412	0	412	0 194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	220	0	0	0	0 194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0 194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	28,139	1,491	0	1,491	0 194.04
194.05	07955	VACANT SPACE	0	0	0	0	0 194.05
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)	4,661,878	1,932,291	141,515	564,961	1,014,184 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.264760	27.870520	2.747757	8.547712	35.277192 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	167,100	565,423	49,477	44,599	163,526 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009490	8.155414	0.960681	0.674771	5.688059 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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	9,437					11.00
13.00	01300	NURSING ADMINISTRATION	634	2,741,722				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	196	0	472,101			14.00
15.00	01500	PHARMACY	279	0	9,212	589,984		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	77,251,164	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,643	1,301,356	31,754	0	3,344,221	30.00
46.00	04600	OTHER LONG TERM CARE	1,499	0	11,903	0	603,340	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	549	340,081	64,325	0	3,633,500	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,962	0	837,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883	0	16,443	0	27,676,809	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	702	0	126,586	0	14,135,473	60.00
65.00	06500	RESPIRATORY THERAPY	142	81,058	1,702	0	416,874	65.00
66.00	06600	PHYSICAL THERAPY	376	0	2,533	0	2,731,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	0	116	0	732,094	67.00
68.00	06800	SPEECH PATHOLOGY	91	0	203	0	250,125	68.00
69.00	06900	ELECTROCARDIOLOGY	100	72,937	19	0	1,439,353	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	124,220	0	616,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	429	0	95,360	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	589,984	5,777,208	73.00
76.00	03610	SLEEP LAB	0	0	1,943	0	242,766	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	180	0	697,413	76.01
76.03	03950	WOUND CARE	45	0	2,140	0	109,819	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	695	0	10,755	0	1,042,658	88.00
91.00	09100	EMERGENCY	1,254	946,290	65,676	0	12,868,299	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)	9,346	2,741,722	472,101	589,984	77,251,164	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	91	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	235,264	930,357	315,081	705,242	78,589	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.929957	0.339333	0.667402	1.195358	0.001017	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,011	35,178	62,787	44,634	31,805	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.019710	0.012831	0.132995	0.075653	0.000412	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,412,343		3,412,343	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	2,244,117		2,244,117	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,240,066		1,240,066	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	412,591		412,591	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,391,600		2,391,600	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,956,638		1,956,638	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	220,425	0	220,425	0	0	65.00
66.00	06600	PHYSICAL THERAPY	880,148	0	880,148	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,901	0	421,901	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	168,518	0	168,518	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	264,027		264,027	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	270,375		270,375	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,091		12,091	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,904		1,590,904	0	0	73.00
76.00	03610	SLEEP LAB	164,820		164,820	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	743,906		743,906	0	0	76.01
76.03	03950	WOUND CARE	114,675		114,675	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,370,990		1,370,990	0	0	88.00
91.00	09100	EMERGENCY	3,665,382		3,665,382	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	371,897		371,897	0	0	92.00
200.00		Subtotal (see instructions)	21,917,414	0	21,917,414	0	0	200.00
201.00		Less Observation Beds	371,897		371,897	0	0	201.00
202.00		Total (see instructions)	21,545,517	0	21,545,517	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 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	2,951,627		2,951,627			30.00
46.00	04600	OTHER LONG TERM CARE	603,340		603,340			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	71,512	3,561,988	3,633,500	0.341287	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	18,315	819,001	837,316	0.492754	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,334,411	26,342,398	27,676,809	0.086412	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,563,144	12,572,329	14,135,473	0.138420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	90,007	326,867	416,874	0.528757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	380,537	2,351,272	2,731,809	0.322185	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,690	392,404	732,094	0.576293	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	125,847	124,278	250,125	0.673735	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	51,042	1,388,311	1,439,353	0.183435	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	267,054	349,673	616,727	0.438403	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,494	90,866	95,360	0.126793	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,232,372	3,544,836	5,777,208	0.275376	0.000000	73.00
76.00	03610	SLEEP LAB	0	242,766	242,766	0.678925	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	697,413	697,413	1.066665	0.000000	76.01
76.03	03950	WOUND CARE	257	109,562	109,819	1.044218	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,042,658	1,042,658			88.00
91.00	09100	EMERGENCY	427,166	12,441,133	12,868,299	0.284838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,049	358,545	392,594	0.947281	0.000000	92.00
200.00		Subtotal (see instructions)	10,494,864	66,756,300	77,251,164			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,494,864	66,756,300	77,251,164			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 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
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
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	03610	SLEEP LAB	0.000000			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.03	03950	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
1.00			2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,412,343		3,412,343	0	3,412,343	30.00
46.00	04600	OTHER LONG TERM CARE	2,244,117		2,244,117	0	2,244,117	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,240,066		1,240,066	0	1,240,066	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	412,591		412,591	0	412,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,391,600		2,391,600	0	2,391,600	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,956,638		1,956,638	0	1,956,638	60.00
65.00	06500	RESPIRATORY THERAPY	220,425	0	220,425	0	220,425	65.00
66.00	06600	PHYSICAL THERAPY	880,148	0	880,148	0	880,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,901	0	421,901	0	421,901	67.00
68.00	06800	SPEECH PATHOLOGY	168,518	0	168,518	0	168,518	68.00
69.00	06900	ELECTROCARDIOLOGY	264,027		264,027	0	264,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	270,375		270,375	0	270,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,091		12,091	0	12,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,904		1,590,904	0	1,590,904	73.00
76.00	03610	SLEEP LAB	164,820		164,820	0	164,820	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	743,906		743,906	0	743,906	76.01
76.03	03950	WOUND CARE	114,675		114,675	0	114,675	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,370,990		1,370,990	0	1,370,990	88.00
91.00	09100	EMERGENCY	3,665,382		3,665,382	0	3,665,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	371,897		371,897	0	371,897	92.00
200.00		Subtotal (see instructions)	21,917,414	0	21,917,414	0	21,917,414	200.00
201.00		Less Observation Beds	371,897		371,897	0	371,897	201.00
202.00		Total (see instructions)	21,545,517	0	21,545,517	0	21,545,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 am

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,951,627		2,951,627			30.00
46.00	04600	OTHER LONG TERM CARE	603,340		603,340			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	71,512	3,561,988	3,633,500	0.341287	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	18,315	819,001	837,316	0.492754	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,334,411	26,342,398	27,676,809	0.086412	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,563,144	12,572,329	14,135,473	0.138420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	90,007	326,867	416,874	0.528757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	380,537	2,351,272	2,731,809	0.322185	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,690	392,404	732,094	0.576293	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	125,847	124,278	250,125	0.673735	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	51,042	1,388,311	1,439,353	0.183435	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	267,054	349,673	616,727	0.438403	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,494	90,866	95,360	0.126793	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,232,372	3,544,836	5,777,208	0.275376	0.000000	73.00
76.00	03610	SLEEP LAB	0	242,766	242,766	0.678925	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	697,413	697,413	1.066665	0.000000	76.01
76.03	03950	WOUND CARE	257	109,562	109,819	1.044218	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,042,658	1,042,658	1.314899	0.000000	88.00
91.00	09100	EMERGENCY	427,166	12,441,133	12,868,299	0.284838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,049	358,545	392,594	0.947281	0.000000	92.00
200.00		Subtotal (see instructions)	10,494,864	66,756,300	77,251,164			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,494,864	66,756,300	77,251,164			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341287			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.492754			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086412			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.138420			60.00
65.00	06500	RESPIRATORY THERAPY	0.528757			65.00
66.00	06600	PHYSICAL THERAPY	0.322185			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.576293			67.00
68.00	06800	SPEECH PATHOLOGY	0.673735			68.00
69.00	06900	ELECTROCARDIOLOGY	0.183435			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.438403			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.126793			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275376			73.00
76.00	03610	SLEEP LAB	0.678925			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.066665			76.01
76.03	03950	WOUND CARE	1.044218			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.314899			88.00
91.00	09100	EMERGENCY	0.284838			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.947281			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Title XIX			Hospital	PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,240,066	144,630	1,095,436	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	412,591	3,962	408,629	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,391,600	211,985	2,179,615	0	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	1,956,638	101,931	1,854,707	0	0
65.00	06500	RESPIRATORY THERAPY	220,425	25,189	195,236	0	0
66.00	06600	PHYSICAL THERAPY	880,148	195,222	684,926	0	0
67.00	06700	OCCUPATIONAL THERAPY	421,901	20,318	401,583	0	0
68.00	06800	SPEECH PATHOLOGY	168,518	9,240	159,278	0	0
69.00	06900	ELECTROCARDIOLOGY	264,027	24,612	239,415	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	270,375	18,381	251,994	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,091	215	11,876	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,904	55,521	1,535,383	0	0
76.00	03610	SLEEP LAB	164,820	17,435	147,385	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	743,906	43,340	700,566	0	0
76.03	03950	WOUND CARE	114,675	19,636	95,039	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,370,990	111,920	1,259,070	0	0
91.00	09100	EMERGENCY	3,665,382	209,214	3,456,168	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	371,897	32,944	338,953	0	0
200.00		Subtotal (sum of lines 50 thru 199)	16,260,954	1,245,695	15,015,259	0	0
201.00		Less Observation Beds	371,897	32,944	338,953	0	0
202.00		Total (line 200 minus line 201)	15,889,057	1,212,751	14,676,306	0	0

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

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,240,066	3,633,500	0.341287	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	412,591	837,316	0.492754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,391,600	27,676,809	0.086412	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,956,638	14,135,473	0.138420	60.00
65.00	06500	RESPIRATORY THERAPY	220,425	416,874	0.528757	65.00
66.00	06600	PHYSICAL THERAPY	880,148	2,731,809	0.322185	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,901	732,094	0.576293	67.00
68.00	06800	SPEECH PATHOLOGY	168,518	250,125	0.673735	68.00
69.00	06900	ELECTROCARDIOLOGY	264,027	1,439,353	0.183435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	270,375	616,727	0.438403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,091	95,360	0.126793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,590,904	5,777,208	0.275376	73.00
76.00	03610	SLEEP LAB	164,820	242,766	0.678925	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	743,906	697,413	1.066665	76.01
76.03	03950	WOUND CARE	114,675	109,819	1.044218	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,370,990	1,042,658	1.314899	88.00
91.00	09100	EMERGENCY	3,665,382	12,868,299	0.284838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	371,897	392,594	0.947281	92.00
200.00		Subtotal (sum of lines 50 thru 199)	16,260,954	73,696,197		200.00
201.00		Less Observation Beds	371,897	0		201.00
202.00		Total (line 200 minus line 201)	15,889,057	73,696,197		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	144,630	3,633,500	0.039805	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	3,962	837,316	0.004732	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	211,985	27,676,809	0.007659	399,698	3,061	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	101,931	14,135,473	0.007211	673,734	4,858	60.00
65.00	06500 RESPIRATORY THERAPY	25,189	416,874	0.060424	38,130	2,304	65.00
66.00	06600 PHYSICAL THERAPY	195,222	2,731,809	0.071463	114,465	8,180	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,318	732,094	0.027753	93,615	2,598	67.00
68.00	06800 SPEECH PATHOLOGY	9,240	250,125	0.036942	52,210	1,929	68.00
69.00	06900 ELECTROCARDIOLOGY	24,612	1,439,353	0.017099	8,862	152	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18,381	616,727	0.029804	172,279	5,135	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	215	95,360	0.002255	2,016	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	55,521	5,777,208	0.009610	1,073,564	10,317	73.00
76.00	03610 SLEEP LAB	17,435	242,766	0.071818	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	43,340	697,413	0.062144	0	0	76.01
76.03	03950 WOUND CARE	19,636	109,819	0.178803	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	111,920	1,042,658	0.107341	0	0	88.00
91.00	09100 EMERGENCY	209,214	12,868,299	0.016258	124,538	2,025	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	32,944	392,594	0.083914	0	0	92.00
200.00	Total (lines 50 through 199)	1,245,695	73,696,197		2,753,111	40,564	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/25/2022 11:30 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,633,500	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	837,316	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,676,809	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	14,135,473	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	416,874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,731,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	732,094	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	250,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,439,353	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	616,727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95,360	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,777,208	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	242,766	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	697,413	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	109,819	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,042,658	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,868,299	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	392,594	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,696,197		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/25/2022 11:30 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	399,698	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	673,734	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	38,130	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	114,465	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	93,615	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	52,210	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,862	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	172,279	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,016	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,073,564	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	124,538	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)		2,753,111	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/25/2022 11:30 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.341287	0	1,142,724	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.492754	0	273,989	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.086412	0	8,542,547	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.138420	0	3,810,662	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.528757	0	117,641	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322185	0	732,608	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.576293	0	108,616	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.673735	0	47,265	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.183435	0	517,111	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.438403	0	118,960	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.126793	0	51,834	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.275376	0	1,378,001	520	0	73.00
76.00	03610	SLEEP LAB	0.678925	0	69,658	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.066665	0	637,990	0	0	76.01
76.03	03950	WOUND CARE	1.044218	0	46,811	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.284838	0	3,495,027	832	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.947281	0	170,553	0	0	92.00
200.00		Subtotal (see instructions)		0	21,261,997	1,352	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	21,261,997	1,352	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/25/2022 11:30 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	389,997	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	135,009	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,179	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	527,472	0					60.00
65.00	06500	RESPIRATORY THERAPY	62,204	0					65.00
66.00	06600	PHYSICAL THERAPY	236,035	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	62,595	0					67.00
68.00	06800	SPEECH PATHOLOGY	31,844	0					68.00
69.00	06900	ELECTROCARDIOLOGY	94,856	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,152	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,572	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,468	143					73.00
76.00	03610	SLEEP LAB	47,293	0					76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	680,522	0					76.01
76.03	03950	WOUND CARE	48,881	0					76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	995,517	237					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,562	0					92.00
200.00		Subtotal (see instructions)	4,650,158	380					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	4,650,158	380					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/25/2022 11:30 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	302,279	99,056	203,223	1,499	135.57	30.00
200.00	Total (lines 30 through 199)	302,279		203,223	1,499		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	22	2,983				30.00
200.00	Total (lines 30 through 199)	22	2,983				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	144,630	3,633,500	0.039805	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	3,962	837,316	0.004732	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,985	27,676,809	0.007659	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	101,931	14,135,473	0.007211	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,189	416,874	0.060424	0	65.00
66.00	06600	PHYSICAL THERAPY	195,222	2,731,809	0.071463	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,318	732,094	0.027753	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,240	250,125	0.036942	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,612	1,439,353	0.017099	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,381	616,727	0.029804	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215	95,360	0.002255	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,521	5,777,208	0.009610	0	73.00
76.00	03610	SLEEP LAB	17,435	242,766	0.071818	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	43,340	697,413	0.062144	0	76.01
76.03	03950	WOUND CARE	19,636	109,819	0.178803	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	111,920	1,042,658	0.107341	0	88.00
91.00	09100	EMERGENCY	209,214	12,868,299	0.016258	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,944	392,594	0.083914	0	92.00
200.00		Total (lines 50 through 199)	1,245,695	73,696,197		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1342		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/25/2022 11:30 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0		0		0		30.00	
200.00		Total (lines 30 through 199)		0		0		0		200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0		0	1,499	0.00	22	30.00	
200.00		Total (lines 30 through 199)				0	1,499		22	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
5/25/2022 11:30 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,633,500	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	837,316	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,676,809	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	14,135,473	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	416,874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,731,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	732,094	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	250,125	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,439,353	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	616,727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95,360	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,777,208	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	242,766	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	697,413	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	109,819	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,042,658	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,868,299	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	392,594	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,696,197		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/25/2022 11:30 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)		2,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,499	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)		1,256	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		723	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		69	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		893	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)		380	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		169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,412,343	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)		11,710	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		1,118,218	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,294,125	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)		2,294,125	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)		1,530.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,366,683	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)		1,366,683	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					682,481	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,049,164	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)					581,567	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)					581,567	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)					243	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,530.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					371,897	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
5/25/2022 11:30 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	302,279	3,412,343	0.088584	371,897	32,944
91.00	Nursing Program cost	0	3,412,343	0.000000	371,897	0
92.00	Allied health cost	0	3,412,343	0.000000	371,897	0
93.00	All other Medical Education	0	3,412,343	0.000000	371,897	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/25/2022 11:30 am	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,499	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.			22	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,234	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			723	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			69	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			22	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)			380	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			169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,412,343	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)			11,710	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			1,118,218	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,294,125	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			19,348	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			19,348	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			118.571687	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)			15.68	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)			2,294,125	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)			1,530.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			33,670	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)			33,670	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					33,670	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)					2,983	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)					2,983	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					30,687	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)					581,567	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)					581,567	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)					243	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,530.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					371,897	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Title XIX		Hospital	PPS	
		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	302,279	3,412,343	0.088584	371,897	32,944
91.00	Nursing Program cost	0	3,412,343	0.000000	371,897	0
92.00	Allied health cost	0	3,412,343	0.000000	371,897	0
93.00	All other Medical Education	0	3,412,343	0.000000	371,897	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/25/2022 11:30 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,087,399		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.341287	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.492754	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086412	399,698	34,539	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.138420	673,734	93,258	60.00
65.00	06500 RESPIRATORY THERAPY	0.528757	38,130	20,162	65.00
66.00	06600 PHYSICAL THERAPY	0.322185	114,465	36,879	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.576293	93,615	53,950	67.00
68.00	06800 SPEECH PATHOLOGY	0.673735	52,210	35,176	68.00
69.00	06900 ELECTROCARDIOLOGY	0.183435	8,862	1,626	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.438403	172,279	75,528	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.126793	2,016	256	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.275376	1,073,564	295,634	73.00
76.00	03610 SLEEP LAB	0.678925	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.066665	0	0	76.01
76.03	03950 WOUND CARE	1.044218	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.284838	124,538	35,473	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.947281	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,753,111	682,481	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)		2,753,111		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342 Component CCN: 14-Z342	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/25/2022 11:30 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.341287	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.492754	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086412	7,409	640	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.138420	119,705	16,570	60.00
65.00	06500 RESPIRATORY THERAPY	0.528757	17,508	9,257	65.00
66.00	06600 PHYSICAL THERAPY	0.322185	140,805	45,365	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.576293	141,579	81,591	67.00
68.00	06800 SPEECH PATHOLOGY	0.673735	16,423	11,065	68.00
69.00	06900 ELECTROCARDIOLOGY	0.183435	4,350	798	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.438403	9,858	4,322	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.126793	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.275376	192,986	53,144	73.00
76.00	03610 SLEEP LAB	0.678925	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.066665	0	0	76.01
76.03	03950 WOUND CARE	1.044218	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.284838	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.947281	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		650,623	222,752	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		650,623		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/25/2022 11:30 am	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.341287	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.492754	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.086412	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.138420	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.528757	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.322185	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.576293	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.673735	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.183435	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.438403	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.126793	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.275376	0	0	73.00
76.00	03610 SLEEP LAB	0.678925	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.066665	0	0	76.01
76.03	03950 WOUND CARE	1.044218	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.314899	0	0	88.00
91.00	09100 EMERGENCY	0.284838	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.947281	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/25/2022 11:30 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,650,538	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,650,538	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		4,697,043	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		52,008	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,284,597	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,360,438	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,360,438	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,360,438	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,134,855	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		737,656	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		979,162	36.00
37.00	Subtotal (see instructions)		2,098,094	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,098,094	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,341,175	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		756,919	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/25/2022 11:30 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		1,418,673		1,341,175	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,418,673		1,341,175	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		458,668		756,919	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,877,341		2,098,094	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: 14-1342

Period:

Worksheet E-1

Component CCN: 14-Z342

From 01/01/2021

Part I

To 12/31/2021

Date/Time Prepared:

5/25/2022 11:30 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		661,892		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		661,892		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		145,463		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		807,355		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: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part II
Date/Time Prepared:
5/25/2022 11:30 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2	
		Component CCN: 14-Z342		Date/Time Prepared: 5/25/2022 11:30 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)		587,383	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)		224,980	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		380	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)		812,363	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		812,363	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)		812,363	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,008	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		807,355	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)		807,355	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		661,892	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)		145,463	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/25/2022 11:30 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,049,164	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)		2,049,164	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,069,656	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)		2,069,656	19.00
20.00	Deductibles (exclude professional component)		225,340	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,844,316	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,844,316	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		50,807	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		33,025	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		39,531	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,877,341	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,877,341	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		1,418,673	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		458,668	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2022 11:30 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0		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		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments			0	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		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)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		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)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	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: 14-1342

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

Worksheet G

Date/Time Prepared:

5/25/2022 11:30 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	-64,220	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	6,114,911	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,392,456	0	0	0	6.00
7.00	Inventory	526,841	0	0	0	7.00
8.00	Prepaid expenses	235,009	0	0	0	8.00
9.00	Other current assets	4,860	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)	4,424,945	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	61,877	0	0	0	13.00
14.00	Accumulated depreciation	-6,345	0	0	0	14.00
15.00	Buildings	2,223,328	0	0	0	15.00
16.00	Accumulated depreciation	-204,183	0	0	0	16.00
17.00	Leasehold improvements	3,375,477	0	0	0	17.00
18.00	Accumulated depreciation	-456,513	0	0	0	18.00
19.00	Fixed equipment	650,296	0	0	0	19.00
20.00	Accumulated depreciation	-101,404	0	0	0	20.00
21.00	Automobiles and trucks	6,317	0	0	0	21.00
22.00	Accumulated depreciation	-4,738	0	0	0	22.00
23.00	Major movable equipment	2,699,297	0	0	0	23.00
24.00	Accumulated depreciation	-612,294	0	0	0	24.00
25.00	Minor equipment depreciable	1,041,019	0	0	0	25.00
26.00	Accumulated depreciation	-252,645	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,419,489	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	3,716,809	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,716,809	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,561,243	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,421,998	0	0	0	37.00
38.00	Salaries, wages, and fees payable	661,934	0	0	0	38.00
39.00	Payroll taxes payable	154,827	0	0	0	39.00
40.00	Notes and loans payable (short term)	72,621	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	15,027,602	0	0	0	43.00
44.00	Other current liabilities	671,429	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,010,411	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)	18,010,411	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,449,168	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,449,168	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,561,243	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1342

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

Worksheet G-1

Date/Time Prepared:
5/25/2022 11:30 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		-140,553		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,308,615				2.00
3.00	Total (sum of line 1 and line 2)		-1,449,168		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)		-1,449,168		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,449,168		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1342

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/25/2022 11:30 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,951,627		2,951,627	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	603,340		603,340	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,554,967		3,554,967	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,554,967		3,554,967	17.00
18.00	Ancillary services	6,478,682	52,913,964	59,392,646	18.00
19.00	Outpatient services	461,215	12,799,678	13,260,893	19.00
20.00	RURAL HEALTH CLINIC	0	1,042,658	1,042,658	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,494,864	66,756,300	77,251,164	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,958,821		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)		24,958,821		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1342

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

Worksheet G-3

Date/Time Prepared:
5/25/2022 11:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,251,164	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,956,588	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,294,576	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,958,821	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,664,245	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	11,152	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	19,085	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	298	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	16,819	24.00
24.50	COVID-19 PHE Funding	1,308,276	24.50
25.00	Total other income (sum of lines 6-24)	1,355,630	25.00
26.00	Total (line 5 plus line 25)	-1,308,615	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)	-1,308,615	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

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

Date/Time Prepared:

5/25/2022 11:30 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	249,229	0	249,229	0	2.00
3.00	Nurse Practitioner	121,797	0	121,797	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	208,553	0	208,553	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	51,418	51,418	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	579,579	51,418	630,997	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	78,000	78,000	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,000	78,000	0	14.00
15.00	Medical Supplies	0	52,980	52,980	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	7,183	7,183	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,163	60,163	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	579,579	189,581	769,160	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
25.01	Telehealth	1,847	0	1,847	0	25.01
25.02	Chronic Care Management	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	1,847	0	1,847	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,284	1,284	0	29.00
30.00	Administrative Costs	62,813	348,194	411,007	-62,813	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,813	349,478	412,291	-62,813	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	644,239	539,059	1,183,298	-62,813	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/25/2022 11:30 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	249,229	2.00
3.00	Nurse Practitioner	0	121,797	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	208,553	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	51,418	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	630,997	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	78,000	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,000	14.00
15.00	Medical Supplies	0	52,980	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	7,183	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,163	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	769,160	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	1,847	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,847	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,284	29.00
30.00	Administrative Costs	-344,056	4,138	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-344,056	5,422	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-344,056	776,429	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342

Period:

Worksheet M-2

Component CCN: 14-3975

From 01/01/2021

To 12/31/2021

Date/Time Prepared:

5/25/2022 11:30 am

				RHC I		Cost		
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4		
		1.00	2.00	3.00	4.00	5.00		
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.00	0	4,200	0		1.00	
2.00	Physician Assistant	2.06	4,214	2,100	4,326		2.00	
3.00	Nurse Practitioner	1.00	1,763	2,100	2,100		3.00	
4.00	Subtotal (sum of lines 1 through 3)	3.06	5,977		6,426	6,426	4.00	
5.00	Visiting Nurse	0.00	0			0	5.00	
6.00	Clinical Psychologist	0.00	0			0	6.00	
7.00	Clinical Social Worker	0.00	0			0	7.00	
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02	
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.06	5,977			6,426	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)						769,160	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						1,847	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						771,007	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.997604	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						5,422	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						594,561	15.00
16.00	Total overhead (sum of lines 14 and 15)						599,983	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						599,983	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						598,545	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						1,367,705	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/25/2022 11:30 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)			1,367,705	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,367,705	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,426	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,426	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			212.84	7.00
			Calculation of Limit (1)		
			Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		87.52	138.55	8.00
9.00	Rate for Program covered visits (see instructions)		212.84	138.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		122	478	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		25,966	66,227	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	92,193	16.00
16.01	Total program charges (see instructions)(from contractor's records)			112,199	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			3,400	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,794	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			59,294	16.04
16.05	Total program cost (see instructions)		0	62,088	16.05
17.00	Primary payer amounts			107	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			15,281	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			18,704	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			61,981	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			61,981	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			61,981	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			53,930	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)			8,051	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/25/2022 11:30 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		53,930	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		53,930	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		8,051	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		61,981	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00