

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: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/28/2021 12:48 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/28/2021	Time: 12:48 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ALBERT WHITE

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	117,360	576,364	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	169,945	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		363,411		0	10.00
10.01	RURAL HEALTH CLINIC II	0		46,152		0	10.01
10.02	RURAL HEALTH CLINIC III	0		108,650		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		145,908		0	10.03
200.00	Total	0	287,305	1,240,485	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: 14-1343		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:48 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 NORTH ALLEN STREET			PO Box:				1.00		
2.00	City: ROBINSON			State: IL		Zip Code: 62454		County: CRAWFORD		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		CRAWFORD MEMORIAL HOSPITAL	141343	99914	1	05/01/2005	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CRAWFORD MEMORIAL HOSPITAL	14Z343	99914		05/01/2005	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		CRAWFORD MEMORIAL HHA	147175	99914		08/01/1979	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		CMH RURAL HEALTH CLINIC	143429	99914		11/11/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC		PALESTINE RURAL HEALTH CLINIC	143486	99914		11/21/2006	N	O	N
15.02	Hospital-Based Health Clinic - RHC		OBLONG RURAL HEALTH CLINIC	143488	99914		05/01/2007	N	O	N
15.03	Hospital-Based Health Clinic - RHC		CMH RURAL HEALTH CLINIC - MED CTR	148611	99914		05/28/2020	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2020	04/30/2021		20.00
21.00	Type of Control (see instructions)						11			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural St	Date of Geogra	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "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: 14-1343		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:48 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
			1.00		2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00
61.20	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
						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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

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

MCRIF32 - 16.12.172.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:48 pm
		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:	243,519	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1343		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 12:48 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	Y	Y	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	N	161.00		
								1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00		
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 12:48 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/15/2021	Y 06/15/2021
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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	54,168.00	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	54,168.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	54,168.00	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	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25 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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,080	14	2,206			1.00
2.00	HMO and other (see instructions)	140	360				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	1,288	0	1,423			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	51			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,368	14	3,680			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		103	257			13.00
14.00	Total (see instructions)	2,368	117	3,937	0.00	321.25	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,565	0	4,550	0.00	9.88	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	5,111	0	22,700	0.00	38.41	26.00
26.01	RURAL HEALTH CLINIC II	539	0	2,377	0.00	4.31	26.01
26.02	RURAL HEALTH CLINIC III	955	0	4,743	0.00	9.06	26.02
26.03	RURAL HEALTH CLINIC IV	292	0	1,813	0.00	7.10	26.03
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	390.01	27.00
28.00	Observation Bed Days		0	350			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	25	51			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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	326	14	736	1.00
2.00 HMO and other (see instructions)			44	152		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	326	14	736	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	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.25 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

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-1343 Component CCN: 14-7175		Period: From 05/01/2020 To 04/30/2021		Worksheet S-4 Date/Time Prepared: 9/28/2021 12:48 pm	
						Home Health Agency I		PPS	
						1.00			
0.00	County					CRAWFORD		0.00	
				Title V	Title XVIII	Title XIX	Other	Total	
				1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours			0	1,395	23	989	2,407	1.00
2.00	Unduplicated Census Count (see instructions)			0.00	138.00	13.00	28.00	179.00	2.00
				Number of Employees (Full Time Equivalent)					
				Enter the number of hours in your normal work week					
						Staff	Contract	Total	
				0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)			40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)					2.00	0.00	2.00	4.00
5.00	Other Administrative Personnel					1.96	0.00	1.96	5.00
6.00	Direct Nursing Service					3.91	0.00	3.91	6.00
7.00	Nursing Supervisor					0.00	0.00	0.00	7.00
8.00	Physical Therapy Service					0.50	0.00	0.50	8.00
9.00	Physical Therapy Supervisor					0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service					0.18	0.00	0.18	10.00
11.00	Occupational Therapy Supervisor					0.00	0.00	0.00	11.00
12.00	Speech Pathology Service					0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor					0.00	0.00	0.00	13.00
14.00	Medical Social Service					0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor					0.00	0.00	0.00	15.00
16.00	Home Health Aide					1.28	0.00	1.28	16.00
17.00	Home Health Aide Supervisor					0.00	0.00	0.00	17.00
18.00	Other (specify)					0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914					20.00
				Full Episodes					
				Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
				1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits			1,099	125	17	3	1,244	21.00
22.00	Skilled Nursing Visit Charges			258,871	29,481	3,555	711	292,618	22.00
23.00	Physical Therapy Visits			804	78	3	1	886	23.00
24.00	Physical Therapy Visit Charges			194,712	18,810	729	243	214,494	24.00
25.00	Occupational Therapy Visits			104	25	0	1	130	25.00
26.00	Occupational Therapy Visit Charges			25,200	6,075	0	243	31,518	26.00
27.00	Speech Pathology Visits			25	26	0	1	52	27.00
28.00	Speech Pathology Visit Charges			6,027	6,318	0	243	12,588	28.00
29.00	Medical Social Service Visits			0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges			0	0	0	0	0	30.00
31.00	Home Health Aide Visits			198	55	0	0	253	31.00
32.00	Home Health Aide Visit Charges			22,308	6,215	0	0	28,523	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)			2,230	309	20	6	2,565	33.00
34.00	Other Charges			27,164	9,036	1,113	0	37,313	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)			534,282	75,935	5,397	1,440	617,054	35.00
36.00	Total Number of Episodes (standard/non outlier)			215		13	1	229	36.00
37.00	Total Number of Outlier Episodes				15		0	15	37.00
38.00	Total Non-Routine Medical Supply Charges			0	0	0	0	0	38.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3429		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 12:48 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1101 N ALLEN			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROBINSON		IL 62454	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				
		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?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		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	CRAWFORD		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	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1343

Period:

Worksheet S-8

Component CCN: 14-3429

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

RHC I

Cost

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

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3486		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 12:48 pm	
		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		209 EAST GRAND PRAIRIE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		PALESTINE IL 62451		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
		Grant Award		Date	
		1.00		2.00	
		Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	
		from to		from to	
		1.00 2.00		3.00 4.00	
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		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)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		CRAWFORD		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		Facility hours of operations (1)		CLINIC	
11.00	CLINIC		16:30	08:00	16:30
		08:00		16:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1343

Period:

Worksheet S-8

Component CCN: 14-3486

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	16:30				11.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3488		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 12:48 pm	
		RHC III		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		1366 E 1050TH AVE		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		OBLONG IL 62449		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00		
7.00	Appalachian Regional Commission		7.00		
8.00	Look-Alikes		8.00		
9.00	OTHER		9.00		
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		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?		Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		14.00		
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		15.00		
		County			
		4.00			
2.00	City, State, ZIP Code, County		CRAWFORD		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: 14-1343

Period:

Worksheet S-8

Component CCN: 14-3488

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

RHC III

Cost

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

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-8611		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 12:48 pm	
		RHC IV		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		1000 N ALLEN ST		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		ROBINSON IL 62454		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
		Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	
		from to		from to	
		1.00 2.00		3.00 4.00	
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
	CLINIC		08:00 17:00		08:00 11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N		0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	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)				5.00 15.00
		County		4.00	
2.00	City, State, ZIP Code, County		CRAWFORD		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	Facility hours of operations (1)				
	CLINIC		17:00 08:00		17:00 08:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1343

Period:

Worksheet S-8

Component CCN: 14-8611

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

RHC IV

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet S-10 Date/Time Prepared: 9/28/2021 12:48 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.480063		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,217,950		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		2,506,502		5.00
6.00	Medicaid charges		25,627,636		6.00
7.00	Medicaid cost (line 1 times line 6)		12,302,880		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)		5,578,428		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)		5,578,428		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)	294,844	208,249	503,093	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	141,544	208,249	349,793	21.00
22.00	Payments received from patients for amounts previously written off as charity care	18,280	12,911	31,191	22.00
23.00	Cost of charity care (line 21 minus line 22)	123,264	195,338	318,602	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,230,228		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		318,687		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		490,287		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,739,941		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,006,881		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,325,483		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,903,911		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,175,956	3,175,956	720,694	3,896,650	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,734,443	1,734,443	33,570	1,768,013	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264,653	5,565,422	5,830,075	1,692	5,831,767	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	67,303	67,303	5.01
5.02	00550	DATA PROCESSING	251,335	2,253,973	2,505,308	0	2,505,308	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	152,282	224,295	376,577	-112,694	263,883	5.03
5.04	00570	ADMITTING	570,607	68,054	638,661	-67,303	571,358	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	691,981	625,176	1,317,157	0	1,317,157	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,616,044	3,467,855	5,083,899	-171,805	4,912,094	5.06
7.00	00700	OPERATION OF PLANT	463,806	1,483,923	1,947,729	0	1,947,729	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,902	44,663	130,565	0	130,565	8.00
9.00	00900	HOUSEKEEPING	396,735	179,471	576,206	0	576,206	9.00
10.00	01000	DIETARY	484,207	336,637	820,844	-534,019	286,825	10.00
11.00	01100	CAFETERIA	0	0	0	534,019	534,019	11.00
13.00	01300	NURSING ADMINISTRATION	647,581	54,510	702,091	0	702,091	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	324,481	324,481	-219,907	104,574	14.00
15.00	01500	PHARMACY	586,987	3,090,956	3,677,943	-2,863,587	814,356	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	390,499	194,523	585,022	0	585,022	16.00
17.00	01700	SOCIAL SERVICE	59,033	4,538	63,571	0	63,571	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	888,618	0	888,618	0	888,618	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,932,848	491,908	3,424,756	-207,037	3,217,719	30.00
43.00	04300	NURSERY	0	15,732	15,732	45,376	61,108	43.00
44.00	04400	SKILLED NURSING FACILITY	-15,083	-2,811	-17,894	17,894	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	890,632	707,037	1,597,669	17,388	1,615,057	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217	217	161,661	161,878	52.00
53.00	05300	ANESTHESIOLOGY	0	98,222	98,222	0	98,222	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,457	718,501	1,434,958	-5,458	1,429,500	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	151,452	35,851	187,303	0	187,303	54.01
60.00	06000	LABORATORY	761,704	1,639,631	2,401,335	0	2,401,335	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	101,473	101,473	0	101,473	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	426,541	151,189	577,730	0	577,730	65.00
66.00	06600	PHYSICAL THERAPY	1,202,512	170,328	1,372,840	-66,179	1,306,661	66.00
69.00	06900	ELECTROCARDIOLOGY	18,591	1,468	20,059	0	20,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	187,493	187,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	139,495	139,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,858,545	2,858,545	73.00
76.97	07697	CARDIAC REHABILITATION	15,942	12,157	28,099	0	28,099	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,154,077	1,150,125	4,304,202	-44,006	4,260,196	88.00
88.01	08801	RURAL HEALTH CLINIC II	269,775	102,450	372,225	0	372,225	88.01
88.02	08802	RURAL HEALTH CLINIC III	697,856	148,273	846,129	0	846,129	88.02
88.03	08803	RURAL HEALTH CLINIC IV	614,051	102,070	716,121	0	716,121	88.03
90.00	09000	CLINIC	2,252,839	2,088,243	4,341,082	-1,275	4,339,807	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	188,605	25,655	214,260	0	214,260	90.01
91.00	09100	EMERGENCY	885,109	2,047,051	2,932,160	0	2,932,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	416,852	114,630	531,482	90,298	621,780	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		624,472	624,472	-624,472	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,131,030	33,372,748	56,503,778	-42,314	56,461,464	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	4,067	2,522	6,589	44,006	50,595	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	54,334	54,334	0	54,334	194.01
194.02	07952	FOUNDATION	60,100	6,431	66,531	0	66,531	194.02
194.03	07953	WELLNESS	61,817	9,006	70,823	-1,692	69,131	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	23,257,014	33,445,041	56,702,055	0	56,702,055	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet A
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-239,072	3,657,578	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,768,013	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-414,036	5,417,731	4.00
5.01	00540	NONPATIENT TELEPHONES	-2,988	64,315	5.01
5.02	00550	DATA PROCESSING	0	2,505,308	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	263,883	5.03
5.04	00570	ADMITTING	0	571,358	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-11,250	1,305,907	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-406,263	4,505,831	5.06
7.00	00700	OPERATION OF PLANT	-1,615	1,946,114	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,565	8.00
9.00	00900	HOUSEKEEPING	0	576,206	9.00
10.00	01000	DIETARY	0	286,825	10.00
11.00	01100	CAFETERIA	-171,223	362,796	11.00
13.00	01300	NURSING ADMINISTRATION	0	702,091	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	104,574	14.00
15.00	01500	PHARMACY	-10,101	804,255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,870	581,152	16.00
17.00	01700	SOCIAL SERVICE	0	63,571	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-888,618	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-958,319	2,259,400	30.00
43.00	04300	NURSERY	-15,000	46,108	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,615,057	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	161,878	52.00
53.00	05300	ANESTHESIOLOGY	-3,376	94,846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-100	1,429,400	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	187,303	54.01
60.00	06000	LABORATORY	0	2,401,335	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	101,473	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-26,920	550,810	65.00
66.00	06600	PHYSICAL THERAPY	-123,261	1,183,400	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	187,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,858,545	73.00
76.97	07697	CARDIAC REHABILITATION	0	28,099	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-613,876	3,646,320	88.00
88.01	08801	RURAL HEALTH CLINIC II	-42,410	329,815	88.01
88.02	08802	RURAL HEALTH CLINIC III	-3,449	842,680	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-4,893	711,228	88.03
90.00	09000	CLINIC	-3,348,143	991,664	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	214,260	90.01
91.00	09100	EMERGENCY	-1,221,660	1,710,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	621,780	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,510,443	47,951,021	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	50,595	192.00
194.00	07950	NONREIMBURSEABLE	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	54,334	194.01
194.02	07952	FOUNDATION	0	66,531	194.02
194.03	07953	WELLNESS	0	69,131	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,510,443	48,191,612	200.00

RECLASSIFICATIONS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
9/28/2021 12:48 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	315,012	219,007		1.00
	TOTALS		315,012	219,007		
	C - PBX COSTS					
1.00	NONPATIENT TELEPHONES	5.01	60,131	7,172		1.00
	TOTALS		60,131	7,172		
	D - LABOR/DEL & NB COSTS					
1.00	NURSERY	43.00	52,775	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	139,804	21,857		2.00
	TOTALS		192,579	21,857		
	E - RADIOLOGY CONTRAST ISOVIEW DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,458		1.00
	TOTALS		0	5,458		
	F - R/C PALESTINE OBLONG DRS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	34,840	9,166		1.00
	TOTALS		34,840	9,166		
	G - HEALTHWORKS COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,444	248		1.00
	TOTALS		1,444	248		
	H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	624,472		1.00
	TOTALS		0	624,472		
	I - PROPERTY TAX PT					
1.00	PHYSICAL THERAPY	66.00	0	24,119		1.00
	TOTALS		0	24,119		
	J - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	139,495		1.00
2.00	OPERATING ROOM	50.00	0	17,388		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	156,883		
	K - RECLASS HHA SALARY IN THERAPY					
1.00	HOME HEALTH AGENCY	101.00	90,298	0		1.00
	TOTALS		90,298	0		
	L - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	129,792		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	129,792		
	M - RECLASS COSTS OF DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,853,087		1.00
	TOTALS		0	2,853,087		
	N - RECLASS COSTS OF MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	187,493		1.00
	TOTALS		0	187,493		
	O - TERMINATED SERVICES TO REMOVE ERROR					
1.00	SKILLED NURSING FACILITY	44.00	15,083	2,811		1.00
	TOTALS		15,083	2,811		
500.00	Grand Total: Increases		709,387	4,241,565		500.00

RECLASSIFICATIONS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
9/28/2021 12:48 pm

		Decreases				wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
		A - CAFETERIA COSTS					
1.00		DIETARY	10.00	315,012	219,007	0	1.00
		TOTALS		315,012	219,007		
		C - PBX COSTS					
1.00		ADMITTING	5.04	60,131	7,172	0	1.00
		TOTALS		60,131	7,172		
		D - LABOR/DEL & NB COSTS					
1.00		ADULTS & PEDIATRICS	30.00	192,579	14,458	0	1.00
2.00		NURSERY	43.00	0	7,399	0	2.00
		TOTALS		192,579	21,857		
		E - RADIOLOGY CONTRAST ISOVIEW DRUGS					
1.00		RADIOLOGY-DIAGNOSTIC	54.00	0	5,458	0	1.00
		TOTALS		0	5,458		
		F - R/C PALESTINE OBLONG DRS					
1.00		RURAL HEALTH CLINIC	88.00	34,840	9,166	0	1.00
		TOTALS		34,840	9,166		
		G - HEALTHWORKS COSTS					
1.00		WELLNESS	194.03	1,444	248	0	1.00
		TOTALS		1,444	248		
		H - INTEREST EXPENSE					
1.00		INTEREST EXPENSE	113.00	0	624,472	11	1.00
		TOTALS		0	624,472		
		I - PROPERTY TAX PT					
1.00		OTHER ADMINISTRATIVE AND GENERAL	5.06	0	24,119	0	1.00
		TOTALS		0	24,119		
		J - IMPLANTABLE DEVICES					
1.00		PURCHASING RECEIVING AND STORES	5.03	0	112,694	0	1.00
2.00		PHARMACY	15.00	0	10,500	0	2.00
3.00		CENTRAL SERVICE & SUPPLY	14.00	0	32,414	0	3.00
4.00		CLINIC	90.00	0	1,275	0	4.00
		TOTALS		0	156,883		
		K - RECLASS HHA SALARY IN THERAPY					
1.00		PHYSICAL THERAPY	66.00	90,298	0	0	1.00
		TOTALS		90,298	0		
		L - PROPERTY INSURANCE					
1.00		OTHER ADMINISTRATIVE AND GENERAL	5.06	0	129,792	12	1.00
2.00			0.00	0	0	12	2.00
		TOTALS		0	129,792		
		M - RECLASS COSTS OF DRUGS SOLD					
1.00		PHARMACY	15.00	0	2,853,087	0	1.00
		TOTALS		0	2,853,087		
		N - RECLASS COSTS OF MEDICAL SUPPLIES					
1.00		CENTRAL SERVICE & SUPPLY	14.00	0	187,493	0	1.00
		TOTALS		0	187,493		
		O - TERMINATED SERVICES TO REMOVE ERROR					
1.00		OTHER ADMINISTRATIVE AND GENERAL	5.06	15,083	2,811	0	1.00
		TOTALS		15,083	2,811		
500.00		Grand Total: Decreases		709,387	4,241,565		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	616,085	0	0	0	75,440	1.00	
2.00	Land Improvements	1,325,717	0	0	0	43,230	2.00	
3.00	Buildings and Fixtures	46,006,047	75,440	0	75,440	25,975	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	10,515,174	0	0	0	421,297	5.00	
6.00	Movable Equipment	20,129,133	650,555	0	650,555	554,020	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	78,592,156	725,995	0	725,995	1,119,962	8.00	
9.00	Reconciling Items	-76,831	-1,196,943	0	-1,196,943	-668,086	9.00	
10.00	Total (line 8 minus line 9)	78,668,987	1,922,938	0	1,922,938	1,788,048	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	540,645	0					1.00
2.00	Land Improvements	1,282,487	0					
3.00	Buildings and Fixtures	46,055,512	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	10,093,877	0					
6.00	Movable Equipment	20,225,668	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	78,198,189	0					
9.00	Reconciling Items	-605,688	0					
10.00	Total (line 8 minus line 9)	78,803,877	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,175,956	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,734,443	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,910,399	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,175,956				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,734,443				2.00
3.00	Total (sum of lines 1-2)	0	4,910,399				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	57,972,521	0	57,972,521	0.741354	96,222	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,225,668	0	20,225,668	0.258646	33,570	2.00
3.00	Total (sum of lines 1-2)	78,198,189	0	78,198,189	1.000000	129,792	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	96,222	3,175,956	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	33,570	1,734,443	0	2.00
3.00	Total (sum of lines 1-2)	0	0	129,792	4,910,399	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	662,475	96,222	0	-277,075	3,657,578	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	33,570	0	0	1,768,013	2.00
3.00	Total (sum of lines 1-2)	662,475	129,792	0	-277,075	5,425,591	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-277,075	CAP REL COSTS-BLDG & FIXT	1.00	14	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,295	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,527,571			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-171,223	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	-3,870	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-888,618	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITING	A	-75,680	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00
34.00	EMPLOYEE INJURY	A	-1,747	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/28/2021 12:48 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00	
34.01	EMPLOYEE PHYSICALS	A		495	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00	ADVERTISING	A		-160,456	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	35.00
36.00	TV ADMINISTRATION	A		-11,367	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	36.00
37.00	TV UTILITIES & REPAIR	A		-1,615	OPERATION OF PLANT	7.00	0	37.00
38.00	EMPLOYEE DISCOUNTS	A		-234,514	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	CONSULTING CLINIC	B		-44,747	CLINIC	90.00	0	39.00
40.00	EMPLOYEE SALES - PHARMACY	B		-10,101	PHARMACY	15.00	0	40.00
41.00	PHYSICIAN AND MID LEVEL EXPENSES	A		-541,840	RURAL HEALTH CLINIC	88.00	0	41.00
41.01	PHYSICIAN AND MID LEVEL EXPENSES	A		-42,000	RURAL HEALTH CLINIC II	88.01	0	41.01
42.00	MISCELLANEOUS INCOME - PFS	B		-11,250	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	42.00
42.01	MISCELLANEOUS INCOME - A&G	B		-10,054	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	42.01
42.02	MISCELLANEOUS INCOME - OB	B		-1,100	ADULTS & PEDIATRICS	30.00	0	42.02
42.03	MISCELLANEOUS INCOME - RHC I	B		-19,413	RURAL HEALTH CLINIC	88.00	0	42.03
42.04	MISCELLANEOUS INCOME - RHC II	B		-410	RURAL HEALTH CLINIC II	88.01	0	42.04
42.05	MISCELLANEOUS INCOME - RHC III	B		-100	RURAL HEALTH CLINIC III	88.02	0	42.05
42.06	MISCELLANEOUS INCOME - PT	B		-27,850	PHYSICAL THERAPY	66.00	0	42.06
43.00	LOBBYING PORTION OF DUES	A		-13,159	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	43.00
44.00	MISCELLANEOUS INCOME - QUALITY	B		-66	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	44.00
45.00	DONATIONS PROJECTS	A		-115,344	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.00
46.00	AMORT BOND ISSUE COST	A		38,003	CAP REL COSTS-BLDG & FIXT	1.00	11	46.00
47.00	MRI RENT	B		-100	RADIOLOGY-DIAGNOSTIC	54.00	0	47.00
48.00	OP THERAPY CENTER RENT	B		-95,411	PHYSICAL THERAPY	66.00	0	48.00
49.00	PHYSICIAN & CRNA BENEFITS	A		-163,802	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.00
49.01	OTHER A&G EXPENSE	A		-20,137	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.01
49.02	PATIENT PHONE COSTS - BENEFITS	A		-166	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.02
49.03	PATIENT PHONE COSTS - SALARY	A		-693	NONPATIENT TELEPHONES	5.01	0	49.03
49.04	RHC PHYSICIAN BENEFITS EXPENSE	A		-14,302	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.04
49.05	NON-RHC EXPENSE	A		-52,623	RURAL HEALTH CLINIC	88.00	0	49.05
49.06	NON-RHC EXPENSE	A		-3,349	RURAL HEALTH CLINIC III	88.02	0	49.06
49.07	NON-RHC EXPENSE	A		-4,893	RURAL HEALTH CLINIC IV	88.03	0	49.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-8,510,443				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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/28/2021 12:48 pm

	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	90.01	PAIN MANAGEMENT CLINIC	SALARIES	188,605	188,605	1.00
2.00	90.01	PAIN MANAGEMENT CLINIC	OTHER EXPENSES	25,655	25,655	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			214,260	214,260	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.

	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	CRAWFORD MEM HOSP PAIN MGMT LLC	51.00	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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/28/2021 12:48 pm

	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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0			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	PAIN MANAGEMENT SERVICES		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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
9/28/2021 12:48 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	957,219	957,219	0	0	0	1.00
2.00	43.00	NURSERY	15,000	15,000	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	3,376	3,376	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	26,920	26,920	0	0	0	4.00
5.00	90.00	CLINIC	3,303,396	3,303,396	0	0	0	5.00
6.00	91.00	EMERGENCY	1,871,416	1,221,660	649,756	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			6,177,327	5,527,571	649,756		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	957,219		1.00
2.00	43.00	NURSERY	0	0	0	15,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	3,376		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	26,920		4.00
5.00	90.00	CLINIC	0	0	0	3,303,396		5.00
6.00	91.00	EMERGENCY	0	0	0	1,221,660		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	5,527,571		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1343		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/28/2021 12:48 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					45	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.80	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	323.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.36	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.18	43.18	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					27,937	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					27,937	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					27,937	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					27,937	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,943	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,943	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					261	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,204	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,204	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
9/28/2021 12:48 pm

		Physical Therapy				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.36	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					27,937	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					2,204	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					30,141	63.00
64.00	Total cost of outside supplier services (from your records)					20,824	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					1,943	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					261	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					2,204	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					261	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					261	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,657,578	3,657,578			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,768,013		1,768,013		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,417,731	35,319	0	5,453,050	4.00
5.01	00540	NONPATIENT TELEPHONES	64,315	0	0	16,636	5.01
5.02	00550	DATA PROCESSING	2,505,308	28,439	714,682	69,535	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	263,883	43,751	24	42,131	5.03
5.04	00570	ADMITTING	571,358	77,671	0	141,230	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,305,907	52,681	3,586	191,446	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	4,505,831	350,661	11,035	442,928	5.06
7.00	00700	OPERATION OF PLANT	1,946,114	237,191	84,914	128,318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,565	52,298	2,753	23,766	8.00
9.00	00900	HOUSEKEEPING	576,206	22,268	2,992	109,762	9.00
10.00	01000	DIETARY	286,825	76,790	2,916	46,810	10.00
11.00	01100	CAFETERIA	362,796	18,512	5,429	87,152	11.00
13.00	01300	NURSING ADMINISTRATION	702,091	8,202	0	179,162	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	104,574	0	0	0	14.00
15.00	01500	PHARMACY	804,255	27,692	94,851	162,398	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	581,152	45,246	2,133	108,037	16.00
17.00	01700	SOCIAL SERVICE	63,571	1,552	0	16,332	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,259,400	386,766	50,236	534,409	30.00
43.00	04300	NURSERY	46,108	12,418	1,250	14,601	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,615,057	379,349	327,073	246,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	161,878	26,331	3,308	38,679	52.00
53.00	05300	ANESTHESIOLOGY	94,846	1,246	20,347	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,429,400	153,618	318,800	198,218	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	187,303	8,394	1,941	41,901	54.01
60.00	06000	LABORATORY	2,401,335	74,912	17,825	210,736	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	101,473	6,267	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	550,810	25,852	36,925	118,009	65.00
66.00	06600	PHYSICAL THERAPY	1,183,400	232,247	799	307,710	66.00
69.00	06900	ELECTROCARDIOLOGY	20,059	0	0	5,143	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	187,493	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,495	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,858,545	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	28,099	36,162	4,451	4,411	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,646,320	249,130	4,521	848,422	88.00
88.01	08801	RURAL HEALTH CLINIC II	329,815	47,737	493	74,637	88.01
88.02	08802	RURAL HEALTH CLINIC III	842,680	99,652	1,659	192,145	88.02
88.03	08803	RURAL HEALTH CLINIC IV	711,228	57,434	0	168,532	88.03
90.00	09000	CLINIC	991,664	300,566	23,319	201,985	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	214,260	26,638	4,041	52,180	90.01
91.00	09100	EMERGENCY	1,710,500	183,782	21,291	244,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	621,780	42,390	1,300	140,310	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,951,021	3,429,164	1,764,894	5,408,955	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	12,725	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	50,595	0	0	10,764	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	54,334	147,849	2,159	0	194.01
194.02	07952	FOUNDATION	66,531	958	0	16,628	194.02
194.03	07953	WELLNESS	69,131	66,882	960	16,703	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,191,612	3,657,578	1,768,013	5,453,050	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,318,788					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	350,819				5.03
5.04	00570	ADMITTING	0	1,279	794,216			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,091,832	1,308	0	3,650,468		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,226,956	2,176	0	0	6,545,972	5.06
7.00	00700	OPERATION OF PLANT	0	4,262	0	0	2,401,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,099	0	0	211,687	8.00
9.00	00900	HOUSEKEEPING	0	4,993	0	0	716,427	9.00
10.00	01000	DIETARY	0	4,973	0	0	419,756	10.00
11.00	01100	CAFETERIA	0	9,260	0	0	483,355	11.00
13.00	01300	NURSING ADMINISTRATION	0	134	0	0	890,207	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	5,931	0	0	110,711	14.00
15.00	01500	PHARMACY	0	18,173	0	0	1,109,429	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	662	0	0	740,732	16.00
17.00	01700	SOCIAL SERVICE	0	8	0	0	81,669	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,680	214,715	207,266	3,669,386	30.00
43.00	04300	NURSERY	0	144	22,887	18,547	116,367	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	32,634	103,218	440,077	3,147,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	328	33,372	34,110	298,624	52.00
53.00	05300	ANESTHESIOLOGY	0	1,139	17,617	53,275	189,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,879	62,035	665,022	2,835,238	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	85	12,301	116,298	368,635	54.01
60.00	06000	LABORATORY	0	24,184	98,923	706,538	3,535,895	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,738	6,088	9,904	129,676	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,967	25,035	41,589	803,599	65.00
66.00	06600	PHYSICAL THERAPY	0	1,042	41,554	153,096	1,923,350	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1	3,027	27,916	56,352	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,602	17,976	49,751	265,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,888	15,016	23,294	185,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	161,320	99,879	384,838	3,504,582	73.00
76.97	07697	CARDIAC REHABILITATION	0	22	0	8,888	82,239	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	15,626	0	241,313	5,015,219	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,590	0	17,185	472,693	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,350	0	41,874	1,186,098	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	14,825	954,079	88.03
90.00	09000	CLINIC	0	7,063	2,101	97,098	1,634,507	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	10,010	307,129	90.01
91.00	09100	EMERGENCY	0	3,921	18,472	265,323	2,449,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,900	0	22,431	831,965	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,318,788	350,361	794,216	3,650,468	47,674,317	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	12,725	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	61,359	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	391	0	0	204,733	194.01
194.02	07952	FOUNDATION	0	4	0	0	84,327	194.02
194.03	07953	WELLNESS	0	63	0	0	154,151	194.03
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)	3,318,788	350,819	794,216	3,650,468	48,191,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	6,545,972					5.06
7.00	00700	OPERATION OF PLANT	377,430	2,778,641				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,274	51,315	296,276			8.00
9.00	00900	HOUSEKEEPING	112,610	21,850	0	850,887		9.00
10.00	01000	DIETARY	65,979	75,346	4,261	25,954	591,296	10.00
11.00	01100	CAFETERIA	75,975	18,164	7,933	6,257	0	11.00
13.00	01300	NURSING ADMINISTRATION	139,925	8,048	0	2,772	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	17,402	0	0	0	0	14.00
15.00	01500	PHARMACY	174,383	27,171	0	9,360	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,430	44,396	0	15,293	0	16.00
17.00	01700	SOCIAL SERVICE	12,837	1,523	0	525	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	576,765	379,497	127,183	130,721	512,400	30.00
43.00	04300	NURSERY	18,291	12,185	1,579	4,197	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	494,672	372,219	60,884	128,217	39,117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,939	25,836	3,701	8,900	0	52.00
53.00	05300	ANESTHESIOLOGY	29,721	1,222	0	421	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	445,651	150,730	20,194	51,921	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	57,943	8,236	0	2,837	0	54.01
60.00	06000	LABORATORY	555,783	73,504	1,596	25,319	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,383	6,149	0	2,118	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	126,312	25,366	2,691	8,738	0	65.00
66.00	06600	PHYSICAL THERAPY	302,318	227,882	0	13,576	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,858	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,783	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	550,861	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	12,927	35,483	0	12,223	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	788,291	244,448	7,014	84,204	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	74,299	46,840	198	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	186,434	97,779	458	33,682	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	149,965	56,355	140	19,412	0	88.03
90.00	09000	CLINIC	256,917	294,917	4,251	101,589	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	48,275	26,137	0	9,003	0	90.01
91.00	09100	EMERGENCY	385,069	180,327	52,985	62,117	39,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	130,771	41,594	0	14,328	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,464,661	2,554,519	295,068	773,684	591,296	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,000	12,486	0	4,301	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	9,645	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	32,181	145,071	0	49,972	0	194.01
194.02	07952	FOUNDATION	13,255	940	0	324	0	194.02
194.03	07953	WELLNESS	24,230	65,625	1,208	22,606	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,545,972	2,778,641	296,276	850,887	591,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	591,684					11.00
13.00	01300	NURSING ADMINISTRATION	22,281	1,063,233				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	128,113			14.00
15.00	01500	PHARMACY	22,281	0	0	1,342,624		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,757	0	0	0	941,608	16.00
17.00	01700	SOCIAL SERVICE	2,476	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,550	392,146	0	7,820	58,517	30.00
43.00	04300	NURSERY	2,476	10,744	0	172	5,236	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,416	261,276	0	12,247	124,247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,427	28,457	0	457	9,630	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14	15,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,135	0	0	3,253	187,756	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	12,378	0	0	0	32,834	54.01
60.00	06000	LABORATORY	34,659	0	0	162	199,439	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	2,796	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,330	0	0	557	11,742	65.00
66.00	06600	PHYSICAL THERAPY	42,086	0	0	12	43,224	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	7,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	73,459	0	14,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	54,654	0	6,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,194,515	108,651	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	2,509	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	94,075	0	0	59,478	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	6,841	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	9,043	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	17,330	0	0	12,118	0	88.03
90.00	09000	CLINIC	24,757	8,738	0	26,534	27,414	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	9,903	0	0	85	2,826	90.01
91.00	09100	EMERGENCY	56,940	253,956	0	9,308	74,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	107,916	0	8	6,333	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	584,257	1,063,233	128,113	1,342,624	941,608	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	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	2,476	0	0	0	0	194.02
194.03	07953	WELLNESS	4,951	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	591,684	1,063,233	128,113	1,342,624	941,608	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	99,030					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,098	0	6,043,083	-91,527	5,951,556	30.00
43.00	04300	NURSERY	0	0	171,247	0	171,247	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	4,699,405	93	4,699,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	429,971	0	429,971	52.00
53.00	05300	ANESTHESIOLOGY	0	0	235,507	0	235,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,731,878	0	3,731,878	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	482,863	0	482,863	54.01
60.00	06000	LABORATORY	0	0	4,426,357	0	4,426,357	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	161,122	0	161,122	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	91,434	91,434	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	996,335	0	996,335	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,552,448	0	2,552,448	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	73,091	0	73,091	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	395,110	0	395,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	276,112	0	276,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,358,609	0	5,358,609	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	145,381	0	145,381	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	6,292,729	0	6,292,729	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	600,871	0	600,871	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,513,494	0	1,513,494	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,209,399	0	1,209,399	88.03
90.00	09000	CLINIC	0	0	2,379,624	0	2,379,624	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	403,358	0	403,358	90.01
91.00	09100	EMERGENCY	6,932	0	3,572,137	0	3,572,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,132,915	0	1,132,915	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,030	0	47,283,046	0	47,283,046	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	31,512	0	31,512	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	71,004	0	71,004	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	431,957	0	431,957	194.01
194.02	07952	FOUNDATION	0	0	101,322	0	101,322	194.02
194.03	07953	WELLNESS	0	0	272,771	0	272,771	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	99,030	0	48,191,612	0	48,191,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

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	35,319	0	35,319	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	108	5.01
5.02	00550	DATA PROCESSING	0	28,439	714,682	743,121	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7,451	43,751	24	51,226	5.03
5.04	00570	ADMITTING	0	77,671	0	77,671	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	52,681	3,586	56,267	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	53,864	350,661	11,035	415,560	5.06
7.00	00700	OPERATION OF PLANT	0	237,191	84,914	322,105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,298	2,753	55,051	8.00
9.00	00900	HOUSEKEEPING	0	22,268	2,992	25,260	9.00
10.00	01000	DIETARY	0	76,790	2,916	79,706	10.00
11.00	01100	CAFETERIA	0	18,512	5,429	23,941	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,202	0	8,202	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	4,558	0	0	4,558	14.00
15.00	01500	PHARMACY	0	27,692	94,851	122,543	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,246	2,133	47,379	16.00
17.00	01700	SOCIAL SERVICE	0	1,552	0	1,552	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	772	386,766	50,236	437,774	30.00
43.00	04300	NURSERY	0	12,418	1,250	13,668	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	104,207	379,349	327,073	810,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,331	3,308	29,639	52.00
53.00	05300	ANESTHESIOLOGY	0	1,246	20,347	21,593	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,618	318,800	472,418	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	8,394	1,941	10,335	54.01
60.00	06000	LABORATORY	75,858	74,912	17,825	168,595	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,267	0	6,267	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,641	25,852	36,925	76,418	65.00
66.00	06600	PHYSICAL THERAPY	24,119	232,247	799	257,165	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	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
76.97	07697	CARDIAC REHABILITATION	0	36,162	4,451	40,613	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	249,130	4,521	253,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	47,737	493	48,230	88.01
88.02	08802	RURAL HEALTH CLINIC III	194	99,652	1,659	101,505	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	57,434	0	57,434	88.03
90.00	09000	CLINIC	10,200	300,566	23,319	334,085	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	26,638	4,041	30,679	90.01
91.00	09100	EMERGENCY	0	183,782	21,291	205,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	42,390	1,300	43,690	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	294,864	3,429,164	1,764,894	5,488,922	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	12,725	0	12,725	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	14,280	147,849	2,159	164,288	194.01
194.02	07952	FOUNDATION	0	958	0	958	194.02
194.03	07953	WELLNESS	0	66,882	960	67,842	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	309,144	3,657,578	1,768,013	5,734,735	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	108					5.01
5.02	00550	DATA PROCESSING	1	743,572				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1	0	51,500			5.03
5.04	00570	ADMITTING	4	0	188	78,778		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5	468,673	192	0	526,377	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9	274,899	319	0	0	5.06
7.00	00700	OPERATION OF PLANT	1	0	626	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	308	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	733	0	0	9.00
10.00	01000	DIETARY	2	0	730	0	0	10.00
11.00	01100	CAFETERIA	0	0	1,359	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1	0	20	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	871	0	0	14.00
15.00	01500	PHARMACY	3	0	2,668	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5	0	97	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14	0	834	21,294	29,885	30.00
43.00	04300	NURSERY	1	0	21	2,270	2,674	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4	0	4,791	10,239	63,453	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1	0	48	3,310	4,918	52.00
53.00	05300	ANESTHESIOLOGY	1	0	167	1,748	7,682	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3	0	863	6,154	95,888	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1	0	12	1,220	16,769	54.01
60.00	06000	LABORATORY	2	0	3,550	9,813	101,900	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	842	604	1,428	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1	0	729	2,483	5,997	65.00
66.00	06600	PHYSICAL THERAPY	5	0	153	4,122	22,074	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	300	4,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,556	1,783	7,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,158	1,490	3,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	23,683	9,908	55,489	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	3	0	1,282	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13	0	2,294	0	34,794	88.00
88.01	08801	RURAL HEALTH CLINIC II	2	0	233	0	2,478	88.01
88.02	08802	RURAL HEALTH CLINIC III	6	0	492	0	6,038	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3	0	0	0	2,138	88.03
90.00	09000	CLINIC	14	0	1,037	208	14,000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	1,443	90.01
91.00	09100	EMERGENCY	2	0	576	1,832	38,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2	0	279	0	3,234	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107	743,572	51,433	78,778	526,377	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	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	57	0	0	194.01
194.02	07952	FOUNDATION	0	0	1	0	0	194.02
194.03	07953	WELLNESS	1	0	9	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108	743,572	51,500	78,778	526,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	693,656					5.06
7.00	00700	OPERATION OF PLANT	39,995	363,558				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,526	6,714	65,753			8.00
9.00	00900	HOUSEKEEPING	11,933	2,859	0	41,496		9.00
10.00	01000	DIETARY	6,991	9,858	946	1,266	99,802	10.00
11.00	01100	CAFETERIA	8,051	2,377	1,761	305	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,827	1,053	0	135	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,844	0	0	0	0	14.00
15.00	01500	PHARMACY	18,479	3,555	0	456	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,338	5,809	0	746	0	16.00
17.00	01700	SOCIAL SERVICE	1,360	199	0	26	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,117	49,653	28,225	6,375	86,486	30.00
43.00	04300	NURSERY	1,938	1,594	351	205	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	52,418	48,701	13,512	6,253	6,602	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,974	3,380	821	434	0	52.00
53.00	05300	ANESTHESIOLOGY	3,149	160	0	21	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,224	19,722	4,482	2,532	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,140	1,078	0	138	0	54.01
60.00	06000	LABORATORY	58,894	9,617	354	1,235	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,160	805	0	103	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,385	3,319	597	426	0	65.00
66.00	06600	PHYSICAL THERAPY	32,035	29,816	0	662	0	66.00
69.00	06900	ELECTROCARDIOLOGY	939	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,428	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,093	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,372	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,370	4,643	0	596	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	83,538	31,984	1,557	4,106	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,873	6,129	44	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,756	12,793	102	1,643	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,891	7,373	31	947	0	88.03
90.00	09000	CLINIC	27,224	38,587	943	4,954	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	5,116	3,420	0	439	0	90.01
91.00	09100	EMERGENCY	40,804	23,594	11,759	3,029	6,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	13,857	5,442	0	699	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	685,039	334,234	65,485	37,731	99,802	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	212	1,634	0	210	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,022	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	3,410	18,981	0	2,437	0	194.01
194.02	07952	FOUNDATION	1,405	123	0	16	0	194.02
194.03	07953	WELLNESS	2,568	8,586	268	1,102	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	693,656	363,558	65,753	41,496	99,802	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	38,359					11.00
13.00	01300	NURSING ADMINISTRATION	1,444	26,842				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	7,273			14.00
15.00	01500	PHARMACY	1,444	0	0	150,200		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,605	0	0	0	68,679	16.00
17.00	01700	SOCIAL SERVICE	160	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,265	9,901	0	875	4,267	30.00
43.00	04300	NURSERY	160	271	0	19	382	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,852	6,596	0	1,370	9,060	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	481	718	0	51	702	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2	1,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,407	0	0	364	13,691	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	802	0	0	0	2,394	54.01
60.00	06000	LABORATORY	2,247	0	0	18	14,561	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	204	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,123	0	0	62	856	65.00
66.00	06600	PHYSICAL THERAPY	2,728	0	0	1	3,152	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	575	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,170	0	1,024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,103	0	480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	133,631	7,922	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	183	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,099	0	0	6,654	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	765	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,012	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,123	0	0	1,356	0	88.03
90.00	09000	CLINIC	1,605	221	0	2,968	1,999	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	642	0	0	10	206	90.01
91.00	09100	EMERGENCY	3,691	6,411	0	1,041	5,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,724	0	1	462	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,878	26,842	7,273	150,200	68,679	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	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	160	0	0	0	0	194.02
194.03	07953	WELLNESS	321	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,359	26,842	7,273	150,200	68,679	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,404					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,166		749,592	0	749,592	30.00
43.00	04300	NURSERY	0		23,649	0	23,649	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		1,039,076	0	1,039,076	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		49,728	0	49,728	52.00
53.00	05300	ANESTHESIOLOGY	0		35,620	0	35,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		667,032	0	667,032	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0		39,160	0	39,160	54.01
60.00	06000	LABORATORY	0		372,151	0	372,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		12,413	0	12,413	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		106,160	0	106,160	65.00
66.00	06600	PHYSICAL THERAPY	0		353,906	0	353,906	66.00
69.00	06900	ELECTROCARDIOLOGY	0		5,872	0	5,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		20,134	0	20,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		12,683	0	12,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		289,005	0	289,005	73.00
76.97	07697	CARDIAC REHABILITATION	0		48,719	0	48,719	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		430,183	0	430,183	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		66,237	0	66,237	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		144,592	0	144,592	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		87,388	0	87,388	88.03
90.00	09000	CLINIC	0		429,153	0	429,153	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0		42,293	0	42,293	90.01
91.00	09100	EMERGENCY	238		350,068	0	350,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		71,299	0	71,299	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,404	0	5,446,113	0	5,446,113	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		14,781	0	14,781	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		1,092	0	1,092	192.00
194.00	07950	NONREIMBURSEABLE	0		0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0		189,173	0	189,173	194.01
194.02	07952	FOUNDATION	0		2,771	0	2,771	194.02
194.03	07953	WELLNESS	0		80,805	0	80,805	194.03
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,404	0	5,734,735	0	5,734,735	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE NEW)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	190,858					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,727,682				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,843	0	19,710,014			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	60,131	393		5.01
5.02	00550	DATA PROCESSING	1,484	698,381	251,335	4	10,000	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,283	23	152,282	5	0	5.03
5.04	00570	ADMITTING	4,053	0	510,476	13	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,749	3,504	691,981	18	6,303	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	18,298	10,783	1,600,961	31	3,697	5.06
7.00	00700	OPERATION OF PLANT	12,377	82,977	463,806	2	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,729	2,690	85,902	1	0	8.00
9.00	00900	HOUSEKEEPING	1,162	2,924	396,735	1	0	9.00
10.00	01000	DIETARY	4,007	2,849	169,195	7	0	10.00
11.00	01100	CAFETERIA	966	5,305	315,012	1	0	11.00
13.00	01300	NURSING ADMINISTRATION	428	0	647,581	3	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	1	0	14.00
15.00	01500	PHARMACY	1,445	92,687	586,987	10	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,361	2,084	390,499	17	0	16.00
17.00	01700	SOCIAL SERVICE	81	0	59,033	1	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,182	49,090	1,931,616	53	0	30.00
43.00	04300	NURSERY	648	1,221	52,775	2	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,795	319,612	890,632	16	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,374	3,233	139,804	3	0	52.00
53.00	05300	ANESTHESIOLOGY	65	19,883	0	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,016	311,528	716,457	11	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	438	1,897	151,452	2	0	54.01
60.00	06000	LABORATORY	3,909	17,418	761,704	7	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	327	0	0	1	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,349	36,083	426,541	2	0	65.00
66.00	06600	PHYSICAL THERAPY	12,119	781	1,112,214	17	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,591	1	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
76.97	07697	CARDIAC REHABILITATION	1,887	4,349	15,942	1	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,000	4,418	3,066,614	48	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,491	482	269,775	6	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,200	1,621	694,507	23	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,997	0	609,158	10	0	88.03
90.00	09000	CLINIC	15,684	22,787	730,072	52	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1,390	3,949	188,605	0	0	90.01
91.00	09100	EMERGENCY	9,590	20,805	885,109	8	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,212	1,270	507,150	9	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,939	1,724,634	19,550,634	390	10,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	664	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	38,907	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	7,715	2,110	0	0	0	194.01
194.02	07952	FOUNDATION	50	0	60,100	1	0	194.02
194.03	07953	WELLNESS	3,490	938	60,373	2	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,657,578	1,768,013	5,453,050	80,951	3,318,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.163871	1.023344	0.276664	205.982188	331.878800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,319	108	743,572	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001792	0.274809	74.357200	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TI ME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE NEW)				
			1.00	2.00				
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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PURCHASING RECEIVING AND STORES (COST REQS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,204,387					5.03
5.04	00570	ADMITTING	22,623	17,364,683				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	23,126	0	98,493,409			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	38,477	0	0	-6,545,972	41,645,640	5.06
7.00	00700	OPERATION OF PLANT	75,370	0	0	0	2,401,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,122	0	0	0	211,687	8.00
9.00	00900	HOUSEKEEPING	88,295	0	0	0	716,427	9.00
10.00	01000	DIETARY	87,955	0	0	0	419,756	10.00
11.00	01100	CAFETERIA	163,758	0	0	0	483,355	11.00
13.00	01300	NURSING ADMINISTRATION	2,363	0	0	0	890,207	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	104,898	0	0	0	110,711	14.00
15.00	01500	PHARMACY	321,399	0	0	0	1,109,429	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,706	0	0	0	740,732	16.00
17.00	01700	SOCIAL SERVICE	141	0	0	0	81,669	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100,455	4,694,387	5,592,249	0	3,669,386	30.00
43.00	04300	NURSERY	2,545	500,411	500,411	0	116,367	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	577,138	2,256,768	11,873,749	0	3,147,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,798	729,642	920,313	0	298,624	52.00
53.00	05300	ANESTHESIOLOGY	20,136	385,170	1,437,423	0	189,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,975	1,356,332	17,943,022	0	2,835,238	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,505	268,943	3,137,842	0	368,635	54.01
60.00	06000	LABORATORY	427,700	2,162,867	19,063,014	0	3,535,895	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	101,473	133,117	267,215	0	129,676	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	87,847	547,377	1,122,108	0	803,599	65.00
66.00	06600	PHYSICAL THERAPY	18,427	908,537	4,130,688	0	1,923,350	66.00
69.00	06900	ELECTROCARDIOLOGY	9	66,187	753,200	0	56,352	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	187,493	393,028	1,342,336	0	265,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,495	328,315	628,509	0	185,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,853,087	2,183,777	10,383,351	0	3,504,582	73.00
76.97	07697	CARDIAC REHABILITATION	393	0	239,803	0	82,239	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	276,346	0	6,510,875	0	5,015,219	88.00
88.01	08801	RURAL HEALTH CLINIC II	28,128	0	463,681	0	472,693	88.01
88.02	08802	RURAL HEALTH CLINIC III	59,248	0	1,129,816	0	1,186,098	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	399,985	0	954,079	88.03
90.00	09000	CLINIC	124,908	45,944	2,619,797	0	1,634,507	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	270,094	0	307,129	90.01
91.00	09100	EMERGENCY	69,344	403,881	7,158,703	0	2,449,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	33,604	0	605,225	0	831,965	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,196,287	17,364,683	98,493,409	-6,545,972	41,128,345	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	12,725	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	61,359	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	6,912	0	0	0	204,733	194.01
194.02	07952	FOUNDATION	68	0	0	0	84,327	194.02
194.03	07953	WELLNESS	1,120	0	0	0	154,151	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	350,819	794,216	3,650,468		6,545,972	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.056544	0.045737	0.037063		0.157183	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,500	78,778	526,377		693,656	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008301	0.004537	0.005344		0.016656	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COST REQS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	147,771				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,729	122,873			8.00
9.00	00900	HOUSEKEEPING	1,162	0	131,366		9.00
10.00	01000	DIETARY	4,007	1,767	4,007	18,744	10.00
11.00	01100	CAFETERIA	966	3,290	966	0	239 11.00
13.00	01300	NURSING ADMINISTRATION	428	0	428	0	9 13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	1,445	0	1,445	0	9 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,361	0	2,361	0	10 16.00
17.00	01700	SOCIAL SERVICE	81	0	81	0	1 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,182	52,746	20,182	16,243	39 30.00
43.00	04300	NURSERY	648	655	648	0	1 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,795	25,250	19,795	1,240	24 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,374	1,535	1,374	0	3 52.00
53.00	05300	ANESTHESIOLOGY	65	0	65	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,016	8,375	8,016	0	15 54.00
54.01	05401	RADIOLOGY-ULTRASOUND	438	0	438	0	5 54.01
60.00	06000	LABORATORY	3,909	662	3,909	0	14 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	327	0	327	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	1,349	1,116	1,349	0	7 65.00
66.00	06600	PHYSICAL THERAPY	12,119	0	2,096	0	17 66.00
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
76.97	07697	CARDIAC REHABILITATION	1,887	0	1,887	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	13,000	2,909	13,000	0	38 88.00
88.01	08801	RURAL HEALTH CLINIC II	2,491	82	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	5,200	190	5,200	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,997	58	2,997	0	7 88.03
90.00	09000	CLINIC	15,684	1,763	15,684	0	10 90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1,390	0	1,390	0	4 90.01
91.00	09100	EMERGENCY	9,590	21,974	9,590	1,261	23 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,212	0	2,212	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,852	122,372	119,447	18,744	236 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	664	0	664	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0 194.00
194.01	07951	PROFESSIONAL BUILDINGS	7,715	0	7,715	0	0 194.01
194.02	07952	FOUNDATION	50	0	50	0	1 194.02
194.03	07953	WELLNESS	3,490	501	3,490	0	2 194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,778,641	296,276	850,887	591,296	591,684 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.803696	2.411238	6.477224	31.545881	2,475.665272 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	363,558	65,753	41,496	99,802	38,359 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.460280	0.535130	0.315881	5.324477	160.497908 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	7.00	8.00	9.00	10.00	11.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	202,468					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	326,988				14.00
15.00	01500	PHARMACY	0	0	3,206,843			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	89,989,052		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,675	0	18,677	5,592,249	93	30.00
43.00	04300	NURSERY	2,046	0	412	500,411	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,754	0	29,251	11,873,749	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,419	0	1,091	920,313	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	34	1,437,423	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,770	17,943,022	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	3,137,842	0	54.01
60.00	06000	LABORATORY	0	0	386	19,063,014	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	267,215	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,331	1,122,108	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	29	4,130,688	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	753,200	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	187,493	0	1,342,336	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,495	0	628,509	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,853,087	10,383,351	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	239,803	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	142,062	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	16,340	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	21,600	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	28,943	0	0	88.03
90.00	09000	CLINIC	1,664	0	63,375	2,619,797	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	204	270,094	0	90.01
91.00	09100	EMERGENCY	48,360	0	22,232	7,158,703	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	20,550	0	19	605,225	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	202,468	326,988	3,206,843	89,989,052	100	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	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	WELLNESS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,063,233	128,113	1,342,624	941,608	99,030	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.251363	0.391797	0.418675	0.010464	990.300000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,842	7,273	150,200	68,679	3,404	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.132574	0.022242	0.046837	0.000763	34.040000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
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: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
88.03	08803	RURAL HEALTH CLINIC IV	88.03
90.00	09000	CLINIC	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	NONREIMBURSEABLE	194.00
194.01	07951	PROFESSIONAL BUILDINGS	194.01
194.02	07952	FOUNDATION	194.02
194.03	07953	WELLNESS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-2

Date/Time Prepared:
9/28/2021 12:48 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY & OR		1	30.00	-91,527 7.00
8.00		IV THERAPY		1	64.00	91,434 8.00
9.00		OR		1	50.00	93 9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,951,556		5,951,556	0	0	30.00
43.00	04300	NURSERY	171,247		171,247	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,699,498		4,699,498	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	429,971		429,971	0	0	52.00
53.00	05300	ANESTHESIOLOGY	235,507		235,507	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,731,878		3,731,878	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	482,863		482,863	0	0	54.01
60.00	06000	LABORATORY	4,426,357		4,426,357	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	161,122		161,122	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	91,434		91,434	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	996,335	0	996,335	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,552,448	0	2,552,448	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	73,091		73,091	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	395,110		395,110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	276,112		276,112	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,358,609		5,358,609	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	145,381		145,381	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,292,729		6,292,729	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	600,871		600,871	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,513,494		1,513,494	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,209,399		1,209,399	0	0	88.03
90.00	09000	CLINIC	2,379,624		2,379,624	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	403,358		403,358	0	0	90.01
91.00	09100	EMERGENCY	3,572,137		3,572,137	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	522,746		522,746	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,132,915		1,132,915		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,805,792	0	47,805,792	0	0	200.00
201.00		Less Observation Beds	522,746		522,746		0	201.00
202.00		Total (see instructions)	47,283,046	0	47,283,046	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,428,942		4,428,942		30.00
43.00	04300	NURSERY	500,327		500,327		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,256,768	9,616,981	11,873,749	0.395789	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	729,642	190,671	920,313	0.467201	52.00
53.00	05300	ANESTHESIOLOGY	385,170	1,052,253	1,437,423	0.163840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,356,332	16,586,690	17,943,022	0.207985	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	268,943	2,868,899	3,137,842	0.153884	54.01
60.00	06000	LABORATORY	2,162,867	16,900,147	19,063,014	0.232196	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	133,117	134,098	267,215	0.602968	62.00
64.00	06400	INTRAVENOUS THERAPY	165,595	451,108	616,703	0.148263	64.00
65.00	06500	RESPIRATORY THERAPY	547,377	574,731	1,122,108	0.887914	65.00
66.00	06600	PHYSICAL THERAPY	908,537	3,222,151	4,130,688	0.617923	66.00
69.00	06900	ELECTROCARDIOLOGY	66,187	687,013	753,200	0.097041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	393,028	949,308	1,342,336	0.294345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	328,315	300,194	628,509	0.439313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,183,777	8,199,574	10,383,351	0.516077	73.00
76.97	07697	CARDIAC REHABILITATION	0	239,803	239,803	0.606252	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,510,875	6,510,875		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	463,681	463,681		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,129,816	1,129,816		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	399,985	399,985		88.03
90.00	09000	CLINIC	45,944	2,573,853	2,619,797	0.908324	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	270,094	270,094	1.493399	90.01
91.00	09100	EMERGENCY	403,881	6,754,822	7,158,703	0.498992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,934	446,754	546,688	0.956205	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	605,225	605,225		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	17,364,683	81,128,726	98,493,409		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	17,364,683	81,128,726	98,493,409		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet C Part I Date/Time Prepared: 9/28/2021 12:48 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,039,076	11,873,749	0.087510	652,547	57,104
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,728	920,313	0.054034	10,106	546
53.00	05300	ANESTHESIOLOGY	35,620	1,437,423	0.024780	107,830	2,672
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,032	17,943,022	0.037175	549,697	20,435
54.01	05401	RADIOLOGY-ULTRASOUND	39,160	3,137,842	0.012480	128,532	1,604
60.00	06000	LABORATORY	372,151	19,063,014	0.019522	774,601	15,122
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,413	267,215	0.046453	76,170	3,538
64.00	06400	INTRAVENOUS THERAPY	0	616,703	0.000000	91,462	0
65.00	06500	RESPIRATORY THERAPY	106,160	1,122,108	0.094608	309,251	29,258
66.00	06600	PHYSICAL THERAPY	353,906	4,130,688	0.085677	142,364	12,197
69.00	06900	ELECTROCARDIOLOGY	5,872	753,200	0.007796	24,748	193
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,134	1,342,336	0.014999	149,744	2,246
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,683	628,509	0.020180	159,099	3,211
73.00	07300	DRUGS CHARGED TO PATIENTS	289,005	10,383,351	0.027833	758,977	21,125
76.97	07697	CARDIAC REHABILITATION	48,719	239,803	0.203163	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	430,183	6,510,875	0.066071	0	0
88.01	08801	RURAL HEALTH CLINIC II	66,237	463,681	0.142850	0	0
88.02	08802	RURAL HEALTH CLINIC III	144,592	1,129,816	0.127978	0	0
88.03	08803	RURAL HEALTH CLINIC IV	87,388	399,985	0.218478	0	0
90.00	09000	CLINIC	429,153	2,619,797	0.163812	818	134
90.01	09001	PAIN MANAGEMENT CLINIC	42,293	270,094	0.156586	0	0
91.00	09100	EMERGENCY	350,068	7,158,703	0.048901	75,827	3,708
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	65,839	546,688	0.120432	15,074	1,815
200.00		Total (lines 50 through 199)	4,667,412	92,958,915		4,026,847	174,908

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0	90.01
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: 14-1343		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part IV Date/Time Prepared: 9/28/2021 12:48 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	11,873,749	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	920,313	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,437,423	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,943,022	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	3,137,842	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	19,063,014	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	267,215	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	616,703	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,122,108	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,130,688	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	753,200	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,342,336	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	628,509	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,383,351	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	239,803	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,510,875	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	463,681	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,129,816	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	399,985	0.000000	88.03
90.00	09000	CLINIC	0	0	0	2,619,797	0.000000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	270,094	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,158,703	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	546,688	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	92,958,915		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	652,547	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	10,106	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	107,830	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	549,697	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	128,532	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	774,601	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	76,170	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	91,462	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	309,251	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	142,364	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	24,748	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	149,744	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	159,099	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	758,977	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	818	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	75,827	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	15,074	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,026,847	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 12:48 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.395789	0	2,670,974	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.467201	0	2,043	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.163840	0	298,432	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207985	0	6,510,013	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.153884	0	830,469	0	0	54.01
60.00	06000	LABORATORY	0.232196	0	6,497,493	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.602968	0	99,419	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.148263	0	116,294	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.887914	0	202,134	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.617923	0	1,011,116	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.097041	0	294,798	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.294345	0	224,456	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439313	0	148,200	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.516077	0	4,769,650	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.606252	0	122,798	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.908324	0	1,196,746	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1.493399	0	88,673	0	0	90.01
91.00	09100	EMERGENCY	0.498992	0	2,422,285	775	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.956205	0	263,033	0	0	92.00
200.00		Subtotal (see instructions)		0	27,769,026	775	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	27,769,026	775	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 12:48 pm

			Title XVIII	Hospital	Cost
	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,057,142	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	954	0	52.00
53.00	05300	ANESTHESIOLOGY	48,895	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,353,985	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	127,796	0	54.01
60.00	06000	LABORATORY	1,508,692	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	59,946	0	62.00
64.00	06400	INTRAVENOUS THERAPY	17,242	0	64.00
65.00	06500	RESPIRATORY THERAPY	179,478	0	65.00
66.00	06600	PHYSICAL THERAPY	624,792	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,607	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,068	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,106	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,461,507	0	73.00
76.97	07697	CARDIAC REHABILITATION	74,447	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	1,087,033	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	132,424	0	90.01
91.00	09100	EMERGENCY	1,208,701	387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	251,513	0	92.00
200.00		Subtotal (see instructions)	10,354,328	387	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,354,328	387	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 9/28/2021 12:48 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,030	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,556	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)		2,206	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,008	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)		415	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		19	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)		32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,080	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)		900	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)		388	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,951,556	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)		3,224	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)		5,431	25.00
26.00	Total swing-bed cost (see instructions)		2,134,005	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,817,551	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)		3,817,551	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)		1,493.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,613,056	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)		1,613,056	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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)					1,577,730
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,190,786
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					1,344,213
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					579,505
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,923,718
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					350
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,493.56
89.00	Observation bed cost (line 87 x line 88) (see instructions)					522,746

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/28/2021 12:48 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	749,592	5,951,556	0.125949	522,746	65,839	90.00
91.00	Nursing School cost	0	5,951,556	0.000000	522,746	0	91.00
92.00	Allied health cost	0	5,951,556	0.000000	522,746	0	92.00
93.00	All other Medical Education	0	5,951,556	0.000000	522,746	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,681,115		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.395789	652,547	258,271	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.467201	10,106	4,722	52.00
53.00	05300 ANESTHESIOLOGY	0.163840	107,830	17,667	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207985	549,697	114,329	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.153884	128,532	19,779	54.01
60.00	06000 LABORATORY	0.232196	774,601	179,859	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.602968	76,170	45,928	62.00
64.00	06400 INTRAVENOUS THERAPY	0.148263	91,462	13,560	64.00
65.00	06500 RESPIRATORY THERAPY	0.887914	309,251	274,588	65.00
66.00	06600 PHYSICAL THERAPY	0.617923	142,364	87,970	66.00
69.00	06900 ELECTROCARDIOLOGY	0.097041	24,748	2,402	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.294345	149,744	44,076	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439313	159,099	69,894	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.516077	758,977	391,691	73.00
76.97	07697 CARDIAC REHABILITATION	0.606252	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	0.908324	818	743	90.00
90.01	09001 PAIN MANAGEMENT CLINIC	1.493399	0	0	90.01
91.00	09100 EMERGENCY	0.498992	75,827	37,837	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.956205	15,074	14,414	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,026,847	1,577,730	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)		4,026,847		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1343 Component CCN: 14-Z343	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 12:48 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.395789	18,570	7,350	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.467201	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.163840	6,754	1,107	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207985	44,737	9,305	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.153884	9,358	1,440	54.01
60.00	06000 LABORATORY	0.232196	223,712	51,945	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.602968	14,560	8,779	62.00
64.00	06400 INTRAVENOUS THERAPY	0.148263	32,621	4,836	64.00
65.00	06500 RESPIRATORY THERAPY	0.887914	74,767	66,387	65.00
66.00	06600 PHYSICAL THERAPY	0.617923	587,451	362,999	66.00
69.00	06900 ELECTROCARDIOLOGY	0.097041	5,380	522	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.294345	22,351	6,579	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439313	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.516077	382,416	197,356	73.00
76.97	07697 CARDIAC REHABILITATION	0.606252	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000 CLINIC	0.908324	1,347	1,224	90.00
90.01	09001 PAIN MANAGEMENT CLINIC	1.493399	0	0	90.01
91.00	09100 EMERGENCY	0.498992	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.956205	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,424,024	719,829	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,424,024		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/28/2021 12:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,354,715	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)		10,354,715	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		10,458,262	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)		80,836	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,210,100	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)		6,167,326	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)		6,167,326	30.00
31.00	Primary payer payments		870	31.00
32.00	Subtotal (line 30 minus line 31)		6,166,456	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)		413,871	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		269,016	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		188,332	36.00
37.00	Subtotal (see instructions)		6,435,472	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)		6,435,472	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		5,859,108	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)		576,364	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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
9/28/2021 12:48 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,725,832		5,700,595	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	01/20/2021	49,189	01/20/2021	158,513	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)		49,189		158,513	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,775,021		5,859,108	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		117,360		576,364	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,892,381		6,435,472	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: 14-1343

Period:

Worksheet E-1

Component CCN: 14-Z343

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:48 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,433,521		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)		2,433,521		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		169,945		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,603,466		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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part II
Date/Time Prepared:
9/28/2021 12:48 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1343

Period:

Worksheet E-2

Component CCN: 14-Z343

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,942,955	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)		727,027	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		1,288	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)		2,669,982	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,669,982	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)		2,669,982	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		72,844	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,597,138	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)		9,735	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		6,328	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,603,466	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		2,433,521	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)		169,945	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: 14-1343	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/28/2021 12:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,190,786	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)		3,190,786	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,222,694	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)		3,222,694	19.00
20.00	Deductibles (exclude professional component)		339,472	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,883,222	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,883,222	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		14,090	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		9,159	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,600	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,892,381	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,892,381	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,775,021	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		117,360	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
9/28/2021 12:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	24,610,815	0	0	0	1.00
2.00	Temporary investments	1,437,828	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,488,903	0	0	0	4.00
5.00	Other receivable	972,411	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,146,316	0	0	0	7.00
8.00	Prepaid expenses	818,992	0	0	0	8.00
9.00	Other current assets	450,000	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)	35,925,265	0	0	0	11.00
FIXED ASSETS						
12.00	Land	540,645	0	0	0	12.00
13.00	Land improvements	1,282,487	0	0	0	13.00
14.00	Accumulated depreciation	-777,514	0	0	0	14.00
15.00	Buildings	46,055,512	0	0	0	15.00
16.00	Accumulated depreciation	-22,971,601	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	10,093,877	0	0	0	19.00
20.00	Accumulated depreciation	-8,835,433	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,225,668	0	0	0	23.00
24.00	Accumulated depreciation	-13,513,876	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	836,473	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,936,238	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	16,894,830	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	6,757,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,652,628	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	92,514,131	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,878,475	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,724,021	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,355,889	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	6,682,179	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	857,957	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,498,521	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,936,258	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,757,798	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,694,056	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,192,577	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	48,321,554	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)	48,321,554	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	92,514,131	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
9/28/2021 12:48 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		47,172,399		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,149,155				2.00
3.00	Total (sum of line 1 and line 2)		48,321,554		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)		48,321,554		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)		48,321,554		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: 14-1343

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
9/28/2021 12:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,518,144		3,518,144	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,411,175		1,411,175	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,929,319		4,929,319	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)	4,929,319		4,929,319	17.00
18.00	Ancillary services	11,885,705	61,887,190	73,772,895	18.00
19.00	Outpatient services	549,659	10,039,008	10,588,667	19.00
20.00	RURAL HEALTH CLINIC	0	6,607,170	6,607,170	20.00
20.01	RURAL HEALTH CLINIC II	0	463,681	463,681	20.01
20.02	RURAL HEALTH CLINIC III	0	1,129,816	1,129,816	20.02
20.03	RURAL HEALTH CLINIC IV	0	399,985	399,985	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		605,225	605,225	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,871,514	10,893,131	12,764,645	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,236,197	92,025,206	111,261,403	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,702,055		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INTEREST EXPENSE	624,472			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)		624,472		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		56,077,583		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
9/28/2021 12:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	111,261,403	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,239,518	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,021,885	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,077,583	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,055,698	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	100,997	6.00
7.00	Income from investments	277,075	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	171,223	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	3,870	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	97,659	22.00
23.00	Governmental appropriations	1,040,423	23.00
24.00	MISCELLANEOUS INCOME	273,431	24.00
24.01	UNREALIZED GAINS ON INVESTMENTS	89,001	24.01
24.02	340B NET INCOME	808,843	24.02
24.50	COVID-19 PHE Funding	1,990,716	24.50
25.00	Total other income (sum of lines 6-24)	4,853,238	25.00
26.00	Total (line 5 plus line 25)	1,797,540	26.00
27.00	INTEREST EXPENSE	624,472	27.00
27.01	LOSS ON SALE OF CAPITAL ASSETS	23,913	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	648,385	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,149,155	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1343

Period: From 05/01/2020

Worksheet H

HHA CCN: 14-7175

To 04/30/2021

Date/Time Prepared: 9/28/2021 12:48 pm

				Home Health Agency I		PPS	
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
		1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0
2.00	Capital Related - Movable Equipment			0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0	0
4.00	Transportation	0	0	0	0	0	0
5.00	Administrative and General	122,880	31,907	7,314	16,041	21,875	200,017
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	234,719	0	13,971	0	0	248,690
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	59,253	0	3,527	0	0	62,780
12.00	Supplies (see instructions)	0	0	0	0	19,976	19,976
13.00	Drugs	0	0	0	0	19	19
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	416,852	31,907	24,812	16,041	41,870	531,482
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	200,017	0	200,017		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	248,690	0	248,690		6.00
7.00	Physical Therapy	70,784	70,784	0	70,784		7.00
8.00	Occupational Therapy	14,670	14,670	0	14,670		8.00
9.00	Speech Pathology	4,844	4,844	0	4,844		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	62,780	0	62,780		11.00
12.00	Supplies (see instructions)	0	19,976	0	19,976		12.00
13.00	Drugs	0	19	0	19		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	90,298	621,780	0	621,780		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1343

Period:

Worksheet H-1

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:48 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
									0
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	200,017	0	0	0	0	200,017	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	248,690	0	0	0	0	248,690	6.00	
7.00	Physical Therapy	70,784	0	0	0	0	70,784	7.00	
8.00	Occupational Therapy	14,670	0	0	0	0	14,670	8.00	
9.00	Speech Pathology	4,844	0	0	0	0	4,844	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	62,780	0	0	0	0	62,780	11.00	
12.00	Supplies (see instructions)	19,976	0	0	0	0	19,976	12.00	
13.00	Drugs	19	0	0	0	0	19	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	621,780	0	0	0	0	621,780	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	200,017						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	117,939	366,629					6.00	
7.00	Physical Therapy	33,569	104,353					7.00	
8.00	Occupational Therapy	6,957	21,627					8.00	
9.00	Speech Pathology	2,297	7,141					9.00	
10.00	Medical Social Services	0	0					10.00	
11.00	Home Health Aide	29,773	92,553					11.00	
12.00	Supplies (see instructions)	9,473	29,449					12.00	
13.00	Drugs	9	28					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		621,780					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1343

Period:

Worksheet H-1

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/28/2021 12:48 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-200,017	5.00
						421,763	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	248,690	6.00
7.00	Physical Therapy	0	0	0	0	70,784	7.00
8.00	Occupational Therapy	0	0	0	0	14,670	8.00
9.00	Speech Pathology	0	0	0	0	4,844	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	62,780	11.00
12.00	Supplies (see instructions)	0	0	0	0	19,976	12.00
13.00	Drugs	0	0	0	0	19	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-200,017	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	200,017	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.474240	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:48 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	42,390	1,300	33,996	1,854	0	1.00
2.00	Skilled Nursing Care	366,629	0	0	64,939	0	0	2.00
3.00	Physical Therapy	104,353	0	0	19,583	0	0	3.00
4.00	Occupational Therapy	21,627	0	0	4,059	0	0	4.00
5.00	Speech Pathology	7,141	0	0	1,340	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	92,553	0	0	16,393	0	0	7.00
8.00	Supplies (see instructions)	29,449	0	0	0	0	0	8.00
9.00	Drugs	28	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	621,780	42,390	1,300	140,310	1,854	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	1,900	0	22,431	103,871	16,327	41,594	1.00
2.00	Skilled Nursing Care	0	0	0	431,568	67,836	0	2.00
3.00	Physical Therapy	0	0	0	123,936	19,481	0	3.00
4.00	Occupational Therapy	0	0	0	25,686	4,037	0	4.00
5.00	Speech Pathology	0	0	0	8,481	1,333	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	108,946	17,124	0	7.00
8.00	Supplies (see instructions)	0	0	0	29,449	4,629	0	8.00
9.00	Drugs	0	0	0	28	4	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,900	0	22,431	831,965	130,771	41,594	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343

Period: From 05/01/2020

Worksheet H-2

HHA CCN: 14-7175

To 04/30/2021

Part I

Date/Time Prepared:

9/28/2021 12:48 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	14,328	0	0	107,916	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	14,328	0	0	107,916	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	19.00	24.00	25.00	
1.00	Administrative and General	8	6,333	0	0	290,377	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	499,404	0	2.00
3.00	Physical Therapy	0	0	0	0	143,417	0	3.00
4.00	Occupational Therapy	0	0	0	0	29,723	0	4.00
5.00	Speech Pathology	0	0	0	0	9,814	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	126,070	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	34,078	0	8.00
9.00	Drugs	0	0	0	0	32	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	8	6,333	0	0	1,132,915	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:48 pmHome Health
Agency I

PPS

Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		26.00	27.00	28.00		
1.00	Administrative and General	290,377				1.00
2.00	Skilled Nursing Care	499,404	172,117	671,521		2.00
3.00	Physical Therapy	143,417	49,428	192,845		3.00
4.00	Occupational Therapy	29,723	10,244	39,967		4.00
5.00	Speech Pathology	9,814	3,382	13,196		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	126,070	43,450	169,520		7.00
8.00	Supplies (see instructions)	34,078	11,745	45,823		8.00
9.00	Drugs	32	11	43		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,132,915	290,377	1,132,915		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.344646			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343

Period: From 05/01/2020

Worksheet H-2

HHA CCN: 14-7175

To 04/30/2021

Part II

Date/Time Prepared: 9/28/2021 12:48 pm

Home Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			Agency 1					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)				NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TI ME)	PURCHASING RECEIVING AND STORES (COST REQS)
1.00	Administrative and General	2,212	1,270	122,880	9	0	33,604	1.00		
2.00	Skilled Nursing Care	0	0	234,719	0	0	0	2.00		
3.00	Physical Therapy	0	0	70,784	0	0	0	3.00		
4.00	Occupational Therapy	0	0	14,670	0	0	0	4.00		
5.00	Speech Pathology	0	0	4,844	0	0	0	5.00		
6.00	Medical Social Services	0	0	0	0	0	0	6.00		
7.00	Home Health Aide	0	0	59,253	0	0	0	7.00		
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00		
9.00	Drugs	0	0	0	0	0	0	9.00		
10.00	DME	0	0	0	0	0	0	10.00		
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00		
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00		
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00		
14.00	Clinic	0	0	0	0	0	0	14.00		
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00		
16.00	Day Care Program	0	0	0	0	0	0	16.00		
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00		
18.00	Homemaker Service	0	0	0	0	0	0	18.00		
19.00	All Others (specify)	0	0	0	0	0	0	19.00		
19.50	Telemedicine	0	0	0	0	0	0	19.50		
20.00	Total (sum of lines 1-19)	2,212	1,270	507,150	9	0	33,604	20.00		
21.00	Total cost to be allocated	42,390	1,300	140,310	1,854	0	1,900	21.00		
22.00	Unit cost multiplier	19.163653	1.023622	0.276664	206.000000	0.000000	0.056541	22.00		
Cost Center Description		ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)			
		5.04	5.05	5A.06	5.06	7.00	8.00			
1.00	Administrative and General	0	605,225	0	103,871	2,212	0	1.00		
2.00	Skilled Nursing Care	0	0	0	431,568	0	0	2.00		
3.00	Physical Therapy	0	0	0	123,936	0	0	3.00		
4.00	Occupational Therapy	0	0	0	25,686	0	0	4.00		
5.00	Speech Pathology	0	0	0	8,481	0	0	5.00		
6.00	Medical Social Services	0	0	0	0	0	0	6.00		
7.00	Home Health Aide	0	0	0	108,946	0	0	7.00		
8.00	Supplies (see instructions)	0	0	0	29,449	0	0	8.00		
9.00	Drugs	0	0	0	28	0	0	9.00		
10.00	DME	0	0	0	0	0	0	10.00		
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00		
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00		
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00		
14.00	Clinic	0	0	0	0	0	0	14.00		
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00		
16.00	Day Care Program	0	0	0	0	0	0	16.00		
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00		
18.00	Homemaker Service	0	0	0	0	0	0	18.00		
19.00	All Others (specify)	0	0	0	0	0	0	19.00		
19.50	Telemedicine	0	0	0	0	0	0	19.50		
20.00	Total (sum of lines 1-19)	0	605,225		831,965	2,212	0	20.00		
21.00	Total cost to be allocated	0	22,431		130,771	41,594	0	21.00		
22.00	Unit cost multiplier	0.000000	0.037062		0.157183	18.803797	0.000000	22.00		

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343
HHA CCN: 14-7175Period:
From 05/01/2020
To 04/30/2021Worksheet H-2
Part II
Date/Time Prepared:
9/28/2021 12:48 pmHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	2,212	0	0	20,550	0	19	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,212	0	0	20,550	0	19	20.00
21.00	Total cost to be allocated	14,328	0	0	107,916	0	8	21.00
22.00	Unit cost multiplier	6.477396	0.000000	0.000000	5.251387	0.000000	0.421053	22.00
Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		16.00	17.00	19.00				
1.00	Administrative and General	605,225	0	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	605,225	0	0				20.00
21.00	Total cost to be allocated	6,333	0	0				21.00
22.00	Unit cost multiplier	0.010464	0.000000	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 12:48 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	671,521		671,521	2,209	303.99	1.00
2.00	Physical Therapy	3.00	192,845	0	192,845	1,413	136.48	2.00
3.00	Occupational Therapy	4.00	39,967	0	39,967	224	178.42	3.00
4.00	Speech Pathology	5.00	13,196	0	13,196	64	206.19	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	169,520		169,520	640	264.88	6.00
7.00	Total (sum of lines 1-6)		1,087,049	0	1,087,049	4,550		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	1,244			8.00
9.00	Physical Therapy		99914	0	886			9.00
10.00	Occupational Therapy		99914	0	130			10.00
11.00	Speech Pathology		99914	0	52			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	253			13.00
14.00	Total (sum of lines 8-13)			0	2,565			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	45,823	0	45,823	37,313	1.228071	15.00
16.00	Cost of Drugs	9.00	43	0	43	0	0.000000	16.00
Cost Center Description		Part A	Program Visits		Cost of Services			
			Part B			Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00	8.00	9.00	10.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,244		0	378,164		1.00
2.00	Physical Therapy	0	886		0	120,921		2.00
3.00	Occupational Therapy	0	130		0	23,195		3.00
4.00	Speech Pathology	0	52		0	10,722		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	253		0	67,015		6.00
7.00	Total (sum of lines 1-6)	0	2,565		0	600,017		7.00
Cost Center Description								
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2020

Part I

To 04/30/2021

Date/Time Prepared:

9/28/2021 12:48 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	37,313	0	0	45,823	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	378,164						1.00
2.00	Physical Therapy	120,921						2.00
3.00	Occupational Therapy	23,195						3.00
4.00	Speech Pathology	10,722						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	67,015						6.00
7.00	Total (sum of lines 1-6)	600,017						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/28/2021 12:48 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.617923	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.294345	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.516077	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1343 HHA CCN: 14-7175	Period: From 05/01/2020 To 04/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	351,346	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	25,973	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	2,780	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	522	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	9,034	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	389,655	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	389,655	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	389,655	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	389,655	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	389,655	31.00
31.01	Sequestration adjustment (see instructions)		0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	389,655	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 HHA CCN: 14-7175	Period: From 05/01/2020 To 04/30/2021	Worksheet H-5 Date/Time Prepared: 9/28/2021 12:48 pm	
		Home Health Agency I		PPS	
		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		0		389,655
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
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)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		389,655
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)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		389,655
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3429

From 05/01/2020

Date/Time Prepared:

To 04/30/2021

9/28/2021 12:48 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,645,816	0	1,645,816	-73,236	1,572,580	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	436,736	0	436,736	-9,655	427,081	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	858,631	0	858,631	0	858,631	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,941,183	0	2,941,183	-82,891	2,858,292	10.00
11.00	Physician Services Under Agreement	0	541,840	541,840	0	541,840	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	541,840	541,840	0	541,840	14.00
15.00	Medical Supplies	0	186,181	186,181	0	186,181	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	79,401	79,401	0	79,401	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	265,582	265,582	0	265,582	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,941,183	807,422	3,748,605	-82,891	3,665,714	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	48,051	48,051	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	48,051	48,051	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	28,293	28,293	0	28,293	29.00
30.00	Administrative Costs	212,894	314,410	527,304	-9,166	518,138	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	212,894	342,703	555,597	-9,166	546,431	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,154,077	1,150,125	4,304,202	-44,006	4,260,196	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3429

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-52,623	1,519,957		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	427,081		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	858,631		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-52,623	2,805,669		10.00
11.00	Physician Services Under Agreement	-541,840	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	-541,840	0		14.00
15.00	Medical Supplies	0	186,181		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	79,401		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	265,582		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-594,463	3,071,251		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	48,051		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	48,051		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	28,293		29.00
30.00	Administrative Costs	-19,413	498,725		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-19,413	527,018		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-613,876	3,646,320		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3486

From 05/01/2020
To 04/30/2021Date/Time Prepared:
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		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	120,430	0	120,430	-2,286	118,144
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	111,893	0	111,893	0	111,893
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	232,323	0	232,323	-2,286	230,037
11.00	Physician Services Under Agreement	0	42,000	42,000	0	42,000
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	42,000	42,000	0	42,000
15.00	Medical Supplies	0	16,340	16,340	0	16,340
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	16,340	16,340	0	16,340
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	232,323	58,340	290,663	-2,286	288,377
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	2,286	2,286
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	2,286	2,286
FACILITY OVERHEAD						
29.00	Facility Costs	0	14,293	14,293	0	14,293
30.00	Administrative Costs	37,452	29,817	67,269	0	67,269
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,452	44,110	81,562	0	81,562
32.00	Total facility costs (sum of lines 22, 28 and 31)	269,775	102,450	372,225	0	372,225

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3486

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	118,144	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	111,893	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	230,037	10.00
11.00	Physician Services Under Agreement	-42,000	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	-42,000	0	14.00
15.00	Medical Supplies	0	16,340	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,340	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-42,000	246,377	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	2,286	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	2,286	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	14,293	29.00
30.00	Administrative Costs	-410	66,859	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-410	81,152	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,410	329,815	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3488

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		RHC III		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	199,627	0	199,627	-15,854	183,773 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	230,850	0	230,850	-7,888	222,962 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	204,420	0	204,420	0	204,420 5.00
6.00	Clinical Psychologist	18,611	0	18,611	-2,922	15,689 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	653,508	0	653,508	-26,664	626,844 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	12,000	12,000	0	12,000 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,000	12,000	0	12,000 14.00
15.00	Medical Supplies	0	23,847	23,847	0	23,847 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	14,164	14,164	0	14,164 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,011	38,011	0	38,011 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	653,508	50,011	703,519	-26,664	676,855 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	26,664	26,664 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	26,664	26,664 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	27,910	27,910	0	27,910 29.00
30.00	Administrative Costs	44,348	70,352	114,700	0	114,700 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	44,348	98,262	142,610	0	142,610 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	697,856	148,273	846,129	0	846,129 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3488

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-3,349	180,424	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	222,962	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	204,420	5.00
6.00	Clinical Psychologist	0	15,689	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-3,349	623,495	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	12,000	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,000	14.00
15.00	Medical Supplies	0	23,847	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	14,164	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	38,011	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,349	673,506	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	26,664	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	26,664	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	27,910	29.00
30.00	Administrative Costs	-100	114,600	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-100	142,510	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,449	842,680	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-8611

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		RHC IV		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	248,012	0	248,012	-8,499	239,513
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	97,294	0	97,294	-2,624	94,670
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	197,138	0	197,138	0	197,138
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	542,444	0	542,444	-11,123	531,321
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	29,267	29,267	0	29,267
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	29,267	29,267	0	29,267
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	542,444	29,267	571,711	-11,123	560,588
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	11,123	11,123
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	11,123	11,123
FACILITY OVERHEAD						
29.00	Facility Costs	0	8,370	8,370	0	8,370
30.00	Administrative Costs	71,607	64,433	136,040	0	136,040
31.00	Total Facility Overhead (sum of lines 29 and 30)	71,607	72,803	144,410	0	144,410
32.00	Total facility costs (sum of lines 22, 28 and 31)	614,051	102,070	716,121	0	716,121

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-8611

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-4,893	234,620	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	94,670	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	197,138	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-4,893	526,428	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	29,267	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,267	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-4,893	555,695	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	11,123	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	11,123	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	8,370	29.00
30.00	Administrative Costs	0	136,040	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	144,410	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,893	711,228	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3429

From 05/01/2020

Date/Time Prepared:

To 04/30/2021

9/28/2021 12:48 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3) 4	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	4.58	13,219	2,856	13,080		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.40	9,481	2,100	7,140		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.98	22,700		20,220	22,700	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)	7.98	22,700			22,700	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,071,251	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					48,051	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,119,302	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.984596	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					527,018	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,646,409	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,173,427	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,173,427	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,124,544	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,195,795	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3486

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.81	2,377	2,100	1,701		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.81	2,377		1,701	2,377	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.81	2,377			2,377	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)					246,377	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,286	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					248,663	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990807	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					81,152	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					271,056	15.00
16.00	Total overhead (sum of lines 14 and 15)					352,208	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					352,208	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					348,970	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					595,347	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3488

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 12:48 pm

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.48	808	1,470	706		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.69	3,731	2,100	3,549		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.17	4,539		4,255	4,539	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.15	204			204	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.32	4,743			4,743	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)					673,506	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					26,664	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					700,170	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.961918	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					142,510	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					670,814	15.00
16.00	Total overhead (sum of lines 14 and 15)					813,324	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					813,324	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					782,351	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,455,857	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-8611

From 05/01/2020

Date/Time Prepared:

To 04/30/2021

9/28/2021 12:48 pm

		RHC IV		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.77	911	1,218	938	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.78	902	1,239	966	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.55	1,813		1,904	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.55	1,813		1,904	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)				555,695	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				11,123	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				566,818	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.980376	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				144,410	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				498,171	15.00
16.00	Total overhead (sum of lines 14 and 15)				642,581	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				642,581	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				629,971	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,185,666	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,195,795	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			106,277	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,089,518	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,700	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)			22,700	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			268.26	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	268.26	268.26	268.26	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,111	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,371,077	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,371,077		16.00
16.01	Total program charges (see instructions)(from contractor's records)		960,616		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		90,723		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		129,489		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.)		908,290		16.04
16.05	Total program cost (see instructions)	0	1,037,779		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		106,225		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		146,146		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,037,779		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		79,101		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,116,880		22.00
23.00	Allowable bad debts (see instructions)		35,320		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		22,958		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		35,320		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)		1,139,838		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		776,427		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)		363,411		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			595,347	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			27,566	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			567,781	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,377	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)			2,377	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			238.86	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	238.86	238.86	238.86	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	539	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	128,746	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	128,746		16.00
16.01	Total program charges (see instructions)(from contractor's records)		106,106		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		29,648		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		35,974		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.)		63,998		16.04
16.05	Total program cost (see instructions)	0	99,972		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,774		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,649		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		99,972		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,380		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		119,352		22.00
23.00	Allowable bad debts (see instructions)		3,696		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,402		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,696		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)		121,754		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		75,602		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		46,152		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC III	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,455,857	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			22,823	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,433,034	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,743	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,743	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			302.14	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	302.14	302.14	302.14	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	917	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	277,062	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	38	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	11,481	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	11,481	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	288,543		16.00
16.01	Total program charges (see instructions)(from contractor's records)		218,732		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,425		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,391		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.)		200,422		16.04
16.05	Total program cost (see instructions)	0	216,813		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,624		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,373		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		216,813		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,266		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		233,079		22.00
23.00	Allowable bad debts (see instructions)		13,300		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		8,645		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,300		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)		241,724		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		133,074		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)		108,650		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343 Component CCN: 14-8611	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC IV	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,185,666	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,487	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,176,179	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,904	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)			1,904	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			617.74	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	617.74	617.74	617.74	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	292	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	180,380	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	180,380		16.00
16.01	Total program charges (see instructions)(from contractor's records)		63,267		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,740		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		33,472		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.)		109,370		16.04
16.05	Total program cost (see instructions)	0	142,842		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,196		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,968		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		142,842		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,480		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		151,322		22.00
23.00	Allowable bad debts (see instructions)		275		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		179		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		275		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)		151,501		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		5,593		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)		145,908		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,805,669	2,805,669	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000555	0.001611	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,557	4,520	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		36,608	9,996	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		38,165	14,516	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,071,251	3,071,251	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,124,544	3,124,544	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.012427	0.004726	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		38,829	14,767	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		76,994	29,283	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		208	604	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		370.16	48.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		171	326	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		63,297	15,804	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			106,277	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			79,101	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		230,037	230,037	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001118	0.003353	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		257	771	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,096	2,284	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,353	3,055	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		246,377	246,377	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		348,970	348,970	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.033903	0.012400	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		11,831	4,327	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		20,184	7,382	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		46	138	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		438.78	53.49	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		36	67	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		15,796	3,584	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			27,566	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			19,380	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		623,495	623,495	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000400	0.001763	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		249	1,099	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,512	2,698	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,761	3,797	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		673,506	673,506	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		782,351	782,351	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010039	0.005638	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,854	4,411	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		14,615	8,208	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		37	163	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		395.00	50.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		32	72	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,640	3,626	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			22,823	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16,266	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-8611	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 12:48 pm	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		526,428	526,428	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000314	0.000243	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		165	128	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,872	281	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,037	409	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		555,695	555,695	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		629,971	629,971	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.007265	0.000736	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,577	464	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		8,614	873	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		22	17	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		391.55	51.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		21	5	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,223	257	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			9,487	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			8,480	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 12:48 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		776,427	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)		776,427	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		363,411	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,139,838	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 12:48 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		75,602	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)		75,602	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		46,152	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		121,754	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 12:48 pm
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		133,074	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)		133,074	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		108,650	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		241,724	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-8611	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 12:48 pm
		RHC IV	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		5,593	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)		5,593	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		145,908	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		151,501	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00