

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

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1346

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

Worksheet S
Parts I-III
Date/Time Prepared:
11/30/2021 8:34 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2021	Time: 8:34 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 FAYETTE COUNTY HOSPITAL (14-1346) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GREG STARNES

Officer or Administrator of Provider(s)

CHEIF EXECUTIVE 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	326,661	-1,107,746	0	-35,172	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		-100,386	0		0	5.00	
6.00	Swing Bed - NF	0				0	6.00	
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00	
10.00	RURAL HEALTH CLINIC I	0		8,796		0	10.00	
10.01	RURAL HEALTH CLINIC II	0		-16,999		0	10.01	
200.00	Total	0	226,275	-1,115,949	0	-35,172	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: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 8:34 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: SEVENTH & TAYLOR			PO Box:				1.00		
2.00	City: VANDALIA			State: IL		Zip Code: 62471-		County: FAYETTE		
		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		FAYETTE COUNTY HOSPITAL	141346	99914	1	04/01/2005	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		FAYETTE COUNTY SNF	142346	99914		04/01/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		FAYETTE COUNTY SNF	145499	99914		07/01/1983	N	P	O
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		VANDALIA	148527	99914		06/01/2013	N	O	N
15.01	Hospital-Based Health Clinic - RHC		ST ELMO	148528	99914		06/01/2013	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 8:34 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 8:34 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	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:			170,356	0	0	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			Y		44.00	122.00
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 8:34 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 8:34 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 8:34 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/29/2021	Y	10/29/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/30/2021 8:34 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JODI	SANDERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & COMPANY LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7956	JSANDERS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 8:34 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	50,496.00	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)		21	7,665	50,496.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	96.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	50,592.00	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	85	31,025		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		110				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: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,355	31	2,104		1.00
2.00	HMO and other (see instructions)	135	165			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	1,473	0	1,473		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	166		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,828	31	3,743		7.00
8.00	INTENSIVE CARE UNIT	2	0	4		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)	2,830	31	3,747	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	8,031	12,935	0.00	19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	1,644	2,245	6,918	0.00	26.00
26.01	RURAL HEALTH CLINIC II	251	333	834	0.00	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		8	408		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	325	7	500	1.00
2.00 HMO and other (see instructions)			27	35		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	325	7	500	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						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
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1346 Component CCN: 14-8527		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/30/2021 8:34 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1442 N 8TH STREET, SUITE C			1.00		
			City		State		ZIP Code		
			1.00		2.00		3.00		
2.00	City, State, ZIP Code, County			VANDALIA IL 62471			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00		17:00		07:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			FAYETTE				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		07:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1346	Period: From 07/01/2020	Worksheet S-8	
			Component CCN: 14-8527	To 06/30/2021	Date/Time Prepared: 11/30/2021 8:34 am	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1346 Component CCN: 14-8528		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/30/2021 8:34 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				428 N MAIN STREET				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				SAINT ELMO		IL 62458		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		12:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				Y				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				FAYETTE				2.00
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC				12:00	13:00	17:00	08:00	12:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 11/30/2021 8:34 am
			RHC II		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					to
11.00	CLINIC				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 8:34 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.396779 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	16,143,112		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	1,334,689		5.00
6.00	Medicaid charges	18,045,564		6.00
7.00	Medicaid cost (line 1 times line 6)	7,160,101		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	734,664	0	734,664 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	291,499	0	291,499 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	291,499	0	291,499 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)	2,822,703		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	767,953		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,181,466		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,641,237		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,064,721		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,356,220		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,356,220		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1346

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

Worksheet A

Date/Time Prepared:
11/30/2021 8:34 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		101,140	101,140	-43,015	58,125	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		578,964	578,964	102,376	681,340	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	180,877	4,149,969	4,330,846	12,790	4,343,636	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,460,186	3,853,211	5,313,397	4,039	5,317,436	5.00
7.00	00700	OPERATION OF PLANT	269,797	241,253	511,050	27,277	538,327	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	524,077	524,077	0	524,077	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	3,387	3,387	0	3,387	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	99,569	72,360	171,929	0	171,929	8.00
9.00	00900	HOUSEKEEPING	419,417	131,494	550,911	0	550,911	9.00
10.00	01000	DIETARY	388,989	414,765	803,754	-252,686	551,068	10.00
11.00	01100	CAFETERIA	0	0	0	252,686	252,686	11.00
13.00	01300	NURSING ADMINISTRATION	133,138	12,086	145,224	0	145,224	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,711	493,756	562,467	-442,881	119,586	14.00
15.00	01500	PHARMACY	210,036	2,694,079	2,904,115	-2,007,232	896,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	418,863	311,183	730,046	0	730,046	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,380,744	298,744	1,679,488	-44,887	1,634,601	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,514	1,514	31.00
44.00	04400	SKILLED NURSING FACILITY	1,675,745	446,679	2,122,424	12,000	2,134,424	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	694,721	675,825	1,370,546	-137,671	1,232,875	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,897	827,019	1,363,916	-164,683	1,199,233	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	132,580	132,580	157,668	290,248	55.00
60.00	06000	LABORATORY	781,649	2,236,289	3,017,938	0	3,017,938	60.00
65.00	06500	RESPIRATORY THERAPY	196,316	103,854	300,170	-24,855	275,315	65.00
66.00	06600	PHYSICAL THERAPY	526,305	60,169	586,474	-250	586,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,870	5,904	86,774	0	86,774	67.00
68.00	06800	SPEECH PATHOLOGY	88,286	6,771	95,057	0	95,057	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	273,743	273,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	294,186	294,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,022,057	2,022,057	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	914,972	150,452	1,065,424	-28,842	1,036,582	88.00
88.01	08801	RURAL HEALTH CLINIC II	115,361	68,621	183,982	4,743	188,725	88.01
90.00	09000	CLINIC	0	600,304	600,304	0	600,304	90.00
90.01	09002	WOUND CARE	21,001	312,302	333,303	0	333,303	90.01
90.02	09003	PAIN MANAGEMENT	0	137,526	137,526	35,153	172,679	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	358,535	36,014	394,549	129,791	524,340	90.04
90.05	09005	DR BLASER	807,067	41,077	848,144	83,806	931,950	90.05
90.06	09006	DR. RONHOLM	0	90,541	90,541	43,147	133,688	90.06
90.07	09007	DR. BARKOVIK	0	123,126	123,126	37,373	160,499	90.07
90.08	04950	NP LANGSTON	112,901	8,471	121,372	0	121,372	90.08
90.09	09008	OP NURSING SERVICE	84,121	8,151	92,272	89,547	181,819	90.09
90.10	09009	DR. RAJU	0	0	0	95,725	95,725	90.10
91.00	09100	EMERGENCY	1,283,706	2,111,449	3,395,155	-14,889	3,380,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,308,780	22,063,592	35,372,372	517,730	35,890,102	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	1,178,382	288,464	1,466,846	-427,032	1,039,814	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	90,698	90,698	-90,698	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	6TH STREET HOURSE	0	3,010	3,010	0	3,010	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	14,487,162	22,445,764	36,932,926	0	36,932,926	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1346

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

Worksheet A

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	857,789	915,914	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	681,340	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,029,002	7,372,638	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,233,215	4,084,221	5.00
7.00	00700	OPERATION OF PLANT	68,736	607,063	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	524,077	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	3,387	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,929	8.00
9.00	00900	HOUSEKEEPING	0	550,911	9.00
10.00	01000	DIETARY	0	551,068	10.00
11.00	01100	CAFETERIA	-89,927	162,759	11.00
13.00	01300	NURSING ADMINISTRATION	0	145,224	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	119,586	14.00
15.00	01500	PHARMACY	-493,903	402,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-35	730,011	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,207	1,630,394	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,514	31.00
44.00	04400	SKILLED NURSING FACILITY	-619,257	1,515,167	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-327,000	905,875	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,199,233	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	290,248	55.00
60.00	06000	LABORATORY	-1	3,017,937	60.00
65.00	06500	RESPIRATORY THERAPY	-24,466	250,849	65.00
66.00	06600	PHYSICAL THERAPY	0	586,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	86,774	67.00
68.00	06800	SPEECH PATHOLOGY	0	95,057	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	273,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	294,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,022,057	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-275	1,036,307	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	188,725	88.01
90.00	09000	CLINIC	0	600,304	90.00
90.01	09002	WOUND CARE	0	333,303	90.01
90.02	09003	PAIN MANAGEMENT	-137,500	35,179	90.02
90.03	09001	NEUROLOGY	0	0	90.03
90.04	09004	DR SKOW	-287,839	236,501	90.04
90.05	09005	DR BLASER	-611,072	320,878	90.05
90.06	09006	DR. RONHOLM	-90,200	43,488	90.06
90.07	09007	DR. BARKOVIK	-123,139	37,360	90.07
90.08	04950	NP LANGSTON	-142,670	-21,298	90.08
90.09	09008	OP NURSING SERVICE	-109,690	72,129	90.09
90.10	09009	DR. RAJU	-55,000	40,725	90.10
91.00	09100	EMERGENCY	-697,257	2,683,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,091,126	34,798,976	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,039,814	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	192.03
192.04	19204	6TH STREET HOUSE	0	3,010	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,091,126	35,841,800	200.00

RECLASSIFICATIONS

Provider CCN: 14-1346

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 8:34 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	122,291	130,395		1.00
	0		122,291	130,395		
	B - AUTO INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	101,140		1.00
	EQUIP					
	TOTALS		0	101,140		
	C - OCCUPATIONAL HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,005	1,790		1.00
	0		12,005	1,790		
	D - WELLNESS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	58,125		1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	1,236		2.00
	EQUIP					
3.00	ADMINISTRATIVE & GENERAL	5.00	0	4,039		3.00
4.00	OPERATION OF PLANT	7.00	0	27,277		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	21		5.00
	0		0	90,698		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	567,908		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	0		0	567,908		
	F - SCU					
1.00	INTENSIVE CARE UNIT	31.00	1,259	255		1.00
	0		1,259	255		
	G - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,022,057		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	2,022,057		
	H - IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	294,186		1.00
	0		0	294,186		
	I - SPECIALTY CLINIC					
1.00	PAIN MANAGEMENT	90.02	28,759	6,394		1.00
2.00	DR SKOW	90.04	116,000	25,791		2.00
3.00	DR BLASER	90.05	68,562	15,244		3.00
4.00	DR. RONHOLM	90.06	35,578	7,910		4.00
5.00	DR. BARKOVIK	90.07	30,575	6,798		5.00
6.00	DR. RAJU	90.10	33,317	7,408		6.00
	0		312,791	69,545		
	J - PROVIDER BASED RECLASS					
1.00	DR. RAJU	90.10	0	55,000		1.00
	0		0	55,000		
	K - OP NURSING SERVICE					
1.00	OP NURSING SERVICE	90.09	74,207	15,346		1.00
	0		74,207	15,346		
	L - RADIOLOGY ADMINISTRATION					
1.00	RADIOLOGY-THERAPEUTIC	55.00	104,965	55,025		1.00
	0		104,965	55,025		
	M - MEDICAL DIRECTOR RECLASS					
1.00	EMERGENCY	91.00	12,000	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	12,000	0		2.00
	0		24,000	0		
	O - RHC OFFICE MANAGER RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	4,743	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	24,099	0		2.00
	TOTALS		28,842	0		

RECLASSIFICATIONS

Provider CCN: 14-1346

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 8:34 am

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
500.00	Grand Total: Increases	680,360	3,403,345			500.00

RECLASSIFICATIONS

Provider CCN: 14-1346

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 8:34 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	122,291	130,395	0		1.00
	0		122,291	130,395			
	B - AUTO INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	101,140	12		1.00
	TOTALS		0	101,140			
	C - OCCUPATIONAL HEALTH						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,005	1,790	0		1.00
	0		12,005	1,790			
	D - WELLNESS						
1.00	FAYETTE COUNTY ANNEX	192.01	0	90,698	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		0	90,698			
	E - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	442,881	0		1.00
2.00	PHARMACY	15.00	0	698	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	26,071	0		3.00
4.00	OPERATING ROOM	50.00	0	44,425	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,458	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	24,855	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	250	0		7.00
8.00	EMERGENCY	91.00	0	26,270	0		8.00
	0		0	567,908			
	F - SCU						
1.00	ADULTS & PEDIATRICS	30.00	1,259	255	0		1.00
	0		1,259	255			
	G - DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,005	0		1.00
2.00	PHARMACY	15.00	0	2,006,534	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	5,302	0		3.00
4.00	OPERATING ROOM	50.00	0	3,693	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,235	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,322	0		6.00
7.00	DR. RONHOLM	90.06	0	341	0		7.00
8.00	OP NURSING SERVICE	90.09	0	6	0		8.00
9.00	EMERGENCY	91.00	0	619	0		9.00
	0		0	2,022,057			
	H - IMPLANTABLES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	294,186	0		1.00
	0		0	294,186			
	I - SPECIALTY CLINIC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	312,791	69,545	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		312,791	69,545			
	J - PROVIDER BASED RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	55,000	0		1.00
	0		0	55,000			
	K - OP NURSING SERVICE						
1.00	OPERATING ROOM	50.00	74,207	15,346	0		1.00
	0		74,207	15,346			
	L - RADIOLOGY ADMINISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	104,965	55,025	0		1.00
	0		104,965	55,025			
	M - MEDICAL DIRECTOR RECLASS						
1.00	DR SKOW	90.04	12,000	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	12,000	0	0		2.00
	0		24,000	0			
	O - RHC OFFICE MANAGER RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	28,842	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		28,842	0			
500.00	Grand Total: Decreases		680,360	3,403,345			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 8:34 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,140,891	477,156	0	477,156	0	6.00
7.00	HIT designated Assets	1,898,111	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,039,002	477,156	0	477,156	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,039,002	477,156	0	477,156	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6,618,047	0				6.00
7.00	HIT designated Assets	1,898,111	0				7.00
8.00	Subtotal (sum of lines 1-7)	8,516,158	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	8,516,158	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	101,140	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	578,964	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	680,104	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	101,140				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	578,964				2.00
3.00	Total (sum of lines 1-2)	0	680,104				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,516,158	0	8,516,158	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	8,516,158	0	8,516,158	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,017,054	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	580,200	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,597,254	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	NEW CAP REL COSTS-BLDG & FIXT	0	-101,140	0	0	915,914	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	101,140	0	0	681,340	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,597,254	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1346

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-15,923	ADMINISTRATIVE & GENERAL	5.00	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	-1,149	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,362,614			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	2,879,029			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,330	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	-35	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	B	-597	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1346

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC EMPLOYEE BENEFIT REVENUE	B	-80	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	RADIOLOGY MISC INCOME	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	LABORATORY MISC INCOME	B	0	LABORATORY	60.00	0	33.02
33.03	DR FUNNEMAN MISC REVENUE	B	-275	RURAL HEALTH CLINIC	88.00	0	33.03
33.04	DR SKOW MISC REVENUE	B	-177	DR SKOW	90.04	0	33.04
33.05	DR BLASER MISC REVENUE	B	-159	DR BLASER	90.05	0	33.05
33.06	DR RONHOLM MISC REVENUE	B	0	DR. RONHOLM	90.06	0	33.06
33.07	DR. BARKOVIK MISC REVENUE	B	-13	DR. BARKOVIK	90.07	0	33.07
34.00	ER MISC REVENUE	B	-264	EMERGENCY	91.00	0	34.00
34.01	AHA LOBBYING DUES PERCENTAGE	A	-3,711	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	IHA LOBBYING DUES PERCENTAGE	A	-9,256	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03	340B EXPENSE OFFSET	A	-493,903	PHARMACY	15.00	0	34.03
34.04	OTHER INCOME - SNF TAX REVENUE	B	-492,000	SKILLED NURSING FACILITY	44.00	0	34.04
34.05	LTC MEDICAID ASSESSMENT	A	-127,257	SKILLED NURSING FACILITY	44.00	0	34.05
34.06	MARKETING EXPENSE	A	-46,412	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	CRNA EXPENSE OFFSET	A	-327,000	OPERATING ROOM	50.00	0	34.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,091,126				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: 14-1346

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 8:34 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DIAGNOSTIC SHARED SERVICES	159,788	159,788	1.00
2.00	60.00	LABORATORY	LAB SAMPLE PROCESSING	918,081	918,082	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	SARAH BUSH LINCOLN	101,140	101,140	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SARAH BUSH LINCOLN	3,364,538	335,456	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SARAH BUSH LINCOLN	1,440,491	1,575,755	3.02
3.03	7.00	OPERATION OF PLANT	SARAH BUSH LINCOLN	68,736	0	3.03
3.04	30.00	ADULTS & PEDIATRICS	SARAH BUSH LINCOLN	80,187	0	3.04
3.05	192.00	PHYSICIANS' PRIVATE OFFICES	SARAH BUSH LINCOLN	500,347	500,347	3.05
3.06	5.00	ADMINISTRATIVE & GENERAL	FAYETTE COUNTY DISTRICT	0	1,021,500	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	FAYETTE COUNTY DISTRICT	857,789	0	3.07
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.			7,491,097	4,612,068	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	
	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	G	SARAH BUSH LINC	100.00		0.00	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:	OTHER			0.00	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.

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

Provider CCN: 14-1346

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 8:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	-1	0		2.00
3.00	0	9		3.00
3.01	3,029,082	0		3.01
3.02	-135,264	0		3.02
3.03	68,736	0		3.03
3.04	80,187	0		3.04
3.05	0	9		3.05
3.06	-1,021,500	0		3.06
3.07	857,789	9		3.07
4.00	0	0		4.00
5.00	2,879,029			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			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: 14-1346

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 8:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	97,583	84,394	13,189	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	24,466	24,466	0	0	0	2.00
3.00	90.02	PAIN MANAGEMENT	137,500	137,500	0	0	0	3.00
4.00	90.04	DR SKOW	308,959	287,662	21,297	0	0	4.00
5.00	90.05	DR BLASER	617,703	610,913	6,790	0	0	5.00
6.00	90.06	DR. RONHOLM	90,200	90,200	0	0	0	6.00
7.00	90.07	DR. BARKOVIK	123,126	123,126	0	0	0	7.00
8.00	90.08	NP LANGSTON	142,670	142,670	0	0	0	8.00
9.00	90.09	OP NURSING SERVICE	109,690	109,690	0	0	0	9.00
10.00	90.10	DR. RAJU	55,000	55,000	0	0	0	10.00
11.00	91.00	EMERGENCY	1,876,644	696,993	1,179,651	0	0	11.00
12.00	44.00	SKILLED NURSING FACILITY	13,027	0	13,027	0	0	12.00
200.00			3,596,568	2,362,614	1,233,954		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.02	PAIN MANAGEMENT	0	0	0	0	0	3.00
4.00	90.04	DR SKOW	0	0	0	0	0	4.00
5.00	90.05	DR BLASER	0	0	0	0	0	5.00
6.00	90.06	DR. RONHOLM	0	0	0	0	0	6.00
7.00	90.07	DR. BARKOVIK	0	0	0	0	0	7.00
8.00	90.08	NP LANGSTON	0	0	0	0	0	8.00
9.00	90.09	OP NURSING SERVICE	0	0	0	0	0	9.00
10.00	90.10	DR. RAJU	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	12.00
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	84,394		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	24,466		2.00
3.00	90.02	PAIN MANAGEMENT	0	0	0	137,500		3.00
4.00	90.04	DR SKOW	0	0	0	287,662		4.00
5.00	90.05	DR BLASER	0	0	0	610,913		5.00
6.00	90.06	DR. RONHOLM	0	0	0	90,200		6.00
7.00	90.07	DR. BARKOVIK	0	0	0	123,126		7.00
8.00	90.08	NP LANGSTON	0	0	0	142,670		8.00
9.00	90.09	OP NURSING SERVICE	0	0	0	109,690		9.00
10.00	90.10	DR. RAJU	0	0	0	55,000		10.00
11.00	91.00	EMERGENCY	0	0	0	696,993		11.00
12.00	44.00	SKILLED NURSING FACILITY	0	0	0	0		12.00
200.00			0	0	0	2,362,614		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	915,914	915,914			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	681,340		681,340		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,372,638	3,102	1,256	7,376,996	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,084,221	61,583	199,691	753,573	5.00
7.00	00700	OPERATION OF PLANT	607,063	310,877	16,690	139,237	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	524,077	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	3,387	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	171,929	20,525	2,806	51,386	8.00
9.00	00900	HOUSEKEEPING	550,911	9,534	1,985	216,453	9.00
10.00	01000	DIETARY	551,068	30,251	14,932	137,638	10.00
11.00	01100	CAFETERIA	162,759	0	0	63,112	11.00
13.00	01300	NURSING ADMINISTRATION	145,224	5,028	0	68,710	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119,586	6,789	0	35,460	14.00
15.00	01500	PHARMACY	402,980	0	11,027	108,395	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	730,011	7,092	0	216,167	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,630,394	44,043	9,636	711,925	30.00
31.00	03100	INTENSIVE CARE UNIT	1,514	4,746	0	650	31.00
44.00	04400	SKILLED NURSING FACILITY	1,515,167	176,501	7,562	864,822	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	905,875	31,407	241,406	320,235	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,199,233	23,476	88,982	222,911	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	290,248	0	0	54,170	55.00
60.00	06000	LABORATORY	3,017,937	27,672	48,739	403,393	60.00
65.00	06500	RESPIRATORY THERAPY	250,849	8,557	6,078	101,315	65.00
66.00	06600	PHYSICAL THERAPY	586,224	17,279	426	271,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	86,774	1,169	0	41,735	67.00
68.00	06800	SPEECH PATHOLOGY	95,057	0	0	45,563	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,743	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	294,186	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,022,057	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,036,307	0	1,911	457,314	88.00
88.01	08801	RURAL HEALTH CLINIC II	188,725	0	0	61,983	88.01
90.00	09000	CLINIC	600,304	11,143	1,743	0	90.00
90.01	09002	WOUND CARE	333,303	1,548	0	10,838	90.01
90.02	09003	PAIN MANAGEMENT	35,179	1,548	0	14,842	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	236,501	7,958	0	238,705	90.04
90.05	09005	DR BLASER	320,878	6,548	0	451,895	90.05
90.06	09006	DR. RONHOLM	43,488	1,548	0	18,361	90.06
90.07	09007	DR. BARKOVIK	37,360	1,548	0	15,779	90.07
90.08	04950	NP LANGSTON	-21,298	2,793	0	58,266	90.08
90.09	09008	OP NURSING SERVICE	72,129	3,370	0	81,710	90.09
90.10	09009	DR. RAJU	40,725	0	0	17,194	90.10
91.00	09100	EMERGENCY	2,683,009	18,799	10,471	668,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,798,976	846,434	665,341	6,924,040	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,130	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,039,814	66,350	15,545	452,956	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	192.03
192.04	19204	6TH STREET HOUSE	3,010	0	454	0	192.04
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)	35,841,800	915,914	681,340	7,376,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,099,068					5.00
7.00	00700	OPERATION OF PLANT	178,115	1,251,982				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	86,925	0	611,002			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	562	0	0	3,949		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	40,909	54,573	27,279	0	369,407	8.00
9.00	00900	HOUSEKEEPING	129,188	25,348	12,670	0	26,754	9.00
10.00	01000	DIETARY	121,725	80,433	40,205	0	3,321	10.00
11.00	01100	CAFETERIA	37,464	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,318	13,369	6,683	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,842	18,051	9,023	0	0	14.00
15.00	01500	PHARMACY	86,647	16,387	8,191	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,112	18,856	9,425	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	397,407	117,102	58,534	0	58,975	30.00
31.00	03100	INTENSIVE CARE UNIT	1,146	12,619	6,308	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	425,281	452,915	226,392	0	180,731	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	248,616	83,506	41,741	0	16,222	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,534	62,419	31,201	0	2,844	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	57,126	0	0	0	0	55.00
60.00	06000	LABORATORY	580,132	73,575	36,777	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	60,838	22,751	11,372	0	52	65.00
66.00	06600	PHYSICAL THERAPY	145,220	45,941	22,964	0	19,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,509	3,109	1,554	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,324	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,404	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	48,795	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	335,384	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	248,053	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	41,583	0	0	0	0	88.01
90.00	09000	CLINIC	101,706	29,628	0	3,949	0	90.00
90.01	09002	WOUND CARE	57,337	4,115	2,057	0	0	90.01
90.02	09003	PAIN MANAGEMENT	8,553	4,115	2,057	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	80,139	21,160	10,577	0	0	90.04
90.05	09005	DR BLASER	129,261	17,411	8,703	0	0	90.05
90.06	09006	DR. RONHOLM	10,515	4,115	2,057	0	0	90.06
90.07	09007	DR. BARKOVIK	9,071	4,115	2,057	0	0	90.07
90.08	04950	NP LANGSTON	6,595	7,425	3,712	0	0	90.08
90.09	09008	OP NURSING SERVICE	26,075	8,961	4,479	0	0	90.09
90.10	09009	DR. RAJU	9,607	0	0	0	0	90.10
91.00	09100	EMERGENCY	560,777	49,983	24,984	0	34,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,836,795	1,251,982	611,002	3,949	342,860	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	519	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	261,179	0	0	0	137	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	103	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	26,307	192.03
192.04	19204	6TH STREET HOUSE	575	0	0	0	0	192.04
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)	5,099,068	1,251,982	611,002	3,949	369,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	972,843					9.00
10.00	01000	DIETARY	57,673	1,037,246				10.00
11.00	01100	CAFETERIA	0	0	263,335			11.00
13.00	01300	NURSING ADMINISTRATION	9,586	0	1,943	286,861		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,943	0	4,497	0	233,191	14.00
15.00	01500	PHARMACY	0	0	4,999	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,520	0	15,370	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	83,965	246,201	46,131	141,688	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,048	82	44	134	0	31.00
44.00	04400	SKILLED NURSING FACILITY	336,486	790,963	72,395	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,876	0	18,077	55,521	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,756	0	14,365	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	3,493	0	0	55.00
60.00	06000	LABORATORY	52,755	0	28,600	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,313	0	6,702	0	0	65.00
66.00	06600	PHYSICAL THERAPY	32,941	0	13,710	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,229	0	1,943	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,921	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	112,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	120,797	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	21,244	0	0	0	0	90.00
90.01	09002	WOUND CARE	2,951	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	2,951	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	15,172	0	0	0	0	90.04
90.05	09005	DR BLASER	12,484	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	2,951	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	2,951	0	0	0	0	90.07
90.08	04950	NP LANGSTON	5,324	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	6,426	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	35,839	0	29,145	89,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	840,384	1,037,246	263,335	286,861	233,191	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,967	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126,492	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	6TH STREET HOUSE	0	0	0	0	0	192.04
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)	972,843	1,037,246	263,335	286,861	233,191	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY					7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	638,626				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,168,553			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	73,906	3,619,907	0	3,619,907
31.00	03100	INTENSIVE CARE UNIT	0	57	36,348	0	36,348
44.00	04400	SKILLED NURSING FACILITY	0	32,715	5,081,930	0	5,081,930
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	51,007	2,073,489	0	2,073,489
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,126	2,180,847	0	2,180,847
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,583	414,620	0	414,620
60.00	06000	LABORATORY	0	282,195	4,551,775	0	4,551,775
65.00	06500	RESPIRATORY THERAPY	0	28,819	513,646	0	513,646
66.00	06600	PHYSICAL THERAPY	0	38,330	1,194,427	0	1,194,427
67.00	06700	OCCUPATIONAL THERAPY	0	6,151	166,173	0	166,173
68.00	06800	SPEECH PATHOLOGY	0	3,406	169,271	0	169,271
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,972	470,513	0	470,513
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,154	480,932	0	480,932
73.00	07300	DRUGS CHARGED TO PATIENTS	638,626	135,044	3,131,111	0	3,131,111
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	16,282	1,759,867	0	1,759,867
88.01	08801	RURAL HEALTH CLINIC II	0	1,965	294,256	0	294,256
90.00	09000	CLINIC	0	26,292	796,009	0	796,009
90.01	09002	WOUND CARE	0	19,538	431,687	0	431,687
90.02	09003	PAIN MANAGEMENT	0	866	70,111	0	70,111
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	0	1,656	611,868	0	611,868
90.05	09005	DR BLASER	0	9,622	956,802	0	956,802
90.06	09006	DR. RONHOLM	0	869	83,904	0	83,904
90.07	09007	DR. BARKOVIK	0	1,340	74,221	0	74,221
90.08	04950	NP LANGSTON	0	1,140	63,957	0	63,957
90.09	09008	OP NURSING SERVICE	0	7,410	210,560	0	210,560
90.10	09009	DR. RAJU	0	0	67,526	0	67,526
91.00	09100	EMERGENCY	0	128,108	4,333,505	0	4,333,505
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	638,626	1,168,553	33,839,262	0	33,839,262
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,616	0	9,616
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,962,473	0	1,962,473
192.01	19201	FAYETTE COUNTY ANNEX	0	0	103	0	103
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	26,307	0	26,307
192.04	19204	6TH STREET HOUSE	0	0	4,039	0	4,039
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	638,626	1,168,553	35,841,800	0	35,841,800

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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11/30/2021 8:34 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,102	1,256	4,358	4,358
5.00	00500	ADMINISTRATIVE & GENERAL	0	61,583	199,691	261,274	445
7.00	00700	OPERATION OF PLANT	0	310,877	16,690	327,567	82
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	0
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,525	2,806	23,331	30
9.00	00900	HOUSEKEEPING	0	9,534	1,985	11,519	128
10.00	01000	DIETARY	0	30,251	14,932	45,183	81
11.00	01100	CAFETERIA	0	0	0	0	37
13.00	01300	NURSING ADMINISTRATION	0	5,028	0	5,028	41
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,789	0	6,789	21
15.00	01500	PHARMACY	0	0	11,027	11,027	64
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,092	0	7,092	128
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	44,043	9,636	53,679	421
31.00	03100	INTENSIVE CARE UNIT	0	4,746	0	4,746	0
44.00	04400	SKILLED NURSING FACILITY	0	176,501	7,562	184,063	511
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	31,407	241,406	272,813	189
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,476	88,982	112,458	132
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	32
60.00	06000	LABORATORY	0	27,672	48,739	76,411	238
65.00	06500	RESPIRATORY THERAPY	0	8,557	6,078	14,635	60
66.00	06600	PHYSICAL THERAPY	0	17,279	426	17,705	161
67.00	06700	OCCUPATIONAL THERAPY	0	1,169	0	1,169	25
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	27
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	1,911	1,911	270
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	37
90.00	09000	CLINIC	0	11,143	1,743	12,886	0
90.01	09002	WOUND CARE	0	1,548	0	1,548	6
90.02	09003	PAIN MANAGEMENT	0	1,548	0	1,548	9
90.03	09001	NEUROLOGY	0	0	0	0	0
90.04	09004	DR SKOW	0	7,958	0	7,958	141
90.05	09005	DR BLASER	0	6,548	0	6,548	267
90.06	09006	DR. RONHOLM	0	1,548	0	1,548	11
90.07	09007	DR. BARKOVIK	0	1,548	0	1,548	9
90.08	04950	NP LANGSTON	0	2,793	0	2,793	34
90.09	09008	OP NURSING SERVICE	0	3,370	0	3,370	48
90.10	09009	DR. RAJU	0	0	0	0	10
91.00	09100	EMERGENCY	0	18,799	10,471	29,270	395
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	846,434	665,341	1,511,775	4,090
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,130	0	3,130	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66,350	15,545	81,895	268
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0
192.04	19204	6TH STREET HOUSE	0	0	454	454	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	915,914	681,340	1,597,254	4,358

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	261,719					5.00
7.00	00700	OPERATION OF PLANT	9,142	336,791				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	4,461	0	4,461			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	29	0	0	29		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,100	14,681	199	0	40,341	8.00
9.00	00900	HOUSEKEEPING	6,631	6,819	93	0	2,922	9.00
10.00	01000	DIETARY	6,248	21,637	294	0	363	10.00
11.00	01100	CAFETERIA	1,923	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,864	3,596	49	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,378	4,856	66	0	0	14.00
15.00	01500	PHARMACY	4,447	4,408	60	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,115	5,072	69	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,397	31,501	427	0	6,440	30.00
31.00	03100	INTENSIVE CARE UNIT	59	3,395	46	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	21,828	121,837	1,651	0	19,736	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,760	22,464	305	0	1,771	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,064	16,791	228	0	311	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,932	0	0	0	0	55.00
60.00	06000	LABORATORY	29,783	19,792	269	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,123	6,120	83	0	6	65.00
66.00	06600	PHYSICAL THERAPY	7,454	12,358	168	0	2,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,104	836	11	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,197	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,330	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,504	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,214	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,731	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,134	0	0	0	0	88.01
90.00	09000	CLINIC	5,220	7,970	0	29	0	90.00
90.01	09002	WOUND CARE	2,943	1,107	15	0	0	90.01
90.02	09003	PAIN MANAGEMENT	439	1,107	15	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	4,113	5,692	77	0	0	90.04
90.05	09005	DR BLASER	6,634	4,684	64	0	0	90.05
90.06	09006	DR. RONHOLM	540	1,107	15	0	0	90.06
90.07	09007	DR. BARKOVIK	466	1,107	15	0	0	90.07
90.08	04950	NP LANGSTON	338	1,997	27	0	0	90.08
90.09	09008	OP NURSING SERVICE	1,338	2,411	33	0	0	90.09
90.10	09009	DR. RAJU	493	0	0	0	0	90.10
91.00	09100	EMERGENCY	28,782	13,446	182	0	3,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	248,258	336,791	4,461	29	37,442	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,405	0	0	0	15	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	11	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	2,873	192.03
192.04	19204	6TH STREET HOUSE	29	0	0	0	0	192.04
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)	261,719	336,791	4,461	29	40,341	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	28,112					9.00
10.00	01000	DIETARY	1,667	75,473				10.00
11.00	01100	CAFETERIA	0	0	1,960			11.00
13.00	01300	NURSING ADMINISTRATION	277	0	14	10,869		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	374	0	33	0	13,517	14.00
15.00	01500	PHARMACY	0	0	37	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	391	0	114	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,426	17,914	343	5,368	0	30.00
31.00	03100	INTENSIVE CARE UNIT	261	6	0	5	0	31.00
44.00	04400	SKILLED NURSING FACILITY	9,726	57,553	541	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,730	0	135	2,104	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,293	0	107	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	26	0	0	55.00
60.00	06000	LABORATORY	1,524	0	213	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	471	0	50	0	0	65.00
66.00	06600	PHYSICAL THERAPY	952	0	102	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64	0	14	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	14	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,002	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	614	0	0	0	0	90.00
90.01	09002	WOUND CARE	85	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	85	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	438	0	0	0	0	90.04
90.05	09005	DR BLASER	361	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	85	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	85	0	0	0	0	90.07
90.08	04950	NP LANGSTON	154	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	186	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	1,036	0	217	3,392	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,285	75,473	1,960	10,869	13,517	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	172	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,655	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	6TH STREET HOUSE	0	0	0	0	0	192.04
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)	28,112	75,473	1,960	10,869	13,517	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY					7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	20,043				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,981			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,327	140,243	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1	8,519	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	587	418,033	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	916	315,187	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,239	148,623	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	172	3,162	0	55.00
60.00	06000	LABORATORY	0	5,068	133,298	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	517	25,065	0	65.00
66.00	06600	PHYSICAL THERAPY	0	688	41,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	110	3,333	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	61	1,299	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	700	9,545	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	308	9,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,043	2,425	39,682	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	292	15,204	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	35	2,206	0	88.01
90.00	09000	CLINIC	0	472	27,191	0	90.00
90.01	09002	WOUND CARE	0	351	6,055	0	90.01
90.02	09003	PAIN MANAGEMENT	0	16	3,219	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	0	30	18,449	0	90.04
90.05	09005	DR BLASER	0	173	18,731	0	90.05
90.06	09006	DR. RONHOLM	0	16	3,322	0	90.06
90.07	09007	DR. BARKOVIK	0	24	3,254	0	90.07
90.08	04950	NP LANGSTON	0	20	5,363	0	90.08
90.09	09008	OP NURSING SERVICE	0	133	7,519	0	90.09
90.10	09009	DR. RAJU	0	0	503	0	90.10
91.00	09100	EMERGENCY	0	2,300	82,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,043	20,981	1,491,320	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,329	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	99,238	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	11	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	2,873	0	192.03
192.04	19204	6TH STREET HOUSE	0	0	483	0	192.04
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,043	20,981	1,597,254	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	133,157					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		578,964				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	451	1,067	14,294,280			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,953	169,686	1,460,186	-5,099,068	30,742,732	5.00
7.00	00700	OPERATION OF PLANT	45,196	14,182	269,797	0	1,073,867	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	524,077	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	3,387	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,984	2,384	99,569	0	246,646	8.00
9.00	00900	HOUSEKEEPING	1,386	1,687	419,417	0	778,883	9.00
10.00	01000	DIETARY	4,398	12,688	266,698	0	733,889	10.00
11.00	01100	CAFETERIA	0	0	122,291	0	225,871	11.00
13.00	01300	NURSING ADMINISTRATION	731	0	133,138	0	218,962	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	987	0	68,711	0	161,835	14.00
15.00	01500	PHARMACY	0	9,370	210,036	0	522,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,031	0	418,863	0	953,270	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,403	8,188	1,379,485	0	2,395,998	30.00
31.00	03100	INTENSIVE CARE UNIT	690	0	1,259	0	6,910	31.00
44.00	04400	SKILLED NURSING FACILITY	25,660	6,426	1,675,745	0	2,564,052	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,566	205,133	620,514	0	1,498,923	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,413	75,612	431,932	0	1,534,602	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	104,965	0	344,418	55.00
60.00	06000	LABORATORY	4,023	41,416	781,649	0	3,497,741	60.00
65.00	06500	RESPIRATORY THERAPY	1,244	5,165	196,316	0	366,799	65.00
66.00	06600	PHYSICAL THERAPY	2,512	362	526,305	0	875,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	0	80,870	0	129,678	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	88,286	0	140,620	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	273,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	294,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,022,057	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,624	886,130	0	1,495,532	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	120,104	0	250,708	88.01
90.00	09000	CLINIC	1,620	1,481	0	0	613,190	90.00
90.01	09002	WOUND CARE	225	0	21,001	0	345,689	90.01
90.02	09003	PAIN MANAGEMENT	225	0	28,759	0	51,569	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	1,157	0	462,535	0	483,164	90.04
90.05	09005	DR BLASER	952	0	875,629	0	779,321	90.05
90.06	09006	DR. RONHOLM	225	0	35,578	0	63,397	90.06
90.07	09007	DR. BARKOVIK	225	0	30,575	0	54,687	90.07
90.08	04950	NP LANGSTON	406	0	112,901	0	39,761	90.08
90.09	09008	OP NURSING SERVICE	490	0	158,328	0	157,209	90.09
90.10	09009	DR. RAJU	0	0	33,317	0	57,919	90.10
91.00	09100	EMERGENCY	2,733	8,898	1,295,706	0	3,380,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,056	565,369	13,416,595	-5,099,068	29,161,473	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	455	0	0	0	3,130	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,646	13,209	877,685	0	1,574,665	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	6TH STREET HOUSE	0	386	0	0	3,464	192.04
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)	915,914	681,340	7,376,996		5,099,068	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.878452	1.176826	0.516080		0.165863	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,358		261,719	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000305		0.008513	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		7.00	7.01	7.02	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	68,457				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	66,837			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	1,620		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,984	2,984	0	403,048	8.00
9.00	00900	HOUSEKEEPING	1,386	1,386	0	29,190	9.00
10.00	01000	DIETARY	4,398	4,398	0	3,623	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	731	731	0	731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	987	987	0	987	14.00
15.00	01500	PHARMACY	896	896	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,031	1,031	0	1,031	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,403	6,403	0	64,346	30.00
31.00	03100	INTENSIVE CARE UNIT	690	690	0	690	31.00
44.00	04400	SKILLED NURSING FACILITY	24,765	24,765	0	197,190	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,566	4,566	0	17,699	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,413	3,413	0	3,103	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	06000	LABORATORY	4,023	4,023	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,244	1,244	0	57	65.00
66.00	06600	PHYSICAL THERAPY	2,512	2,512	0	21,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	170	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	1,620	0	1,620	0	90.00
90.01	09002	WOUND CARE	225	225	0	225	90.01
90.02	09003	PAIN MANAGEMENT	225	225	0	225	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	1,157	1,157	0	1,157	90.04
90.05	09005	DR BLASER	952	952	0	952	90.05
90.06	09006	DR. RONHOLM	225	225	0	225	90.06
90.07	09007	DR. BARKOVIK	225	225	0	225	90.07
90.08	04950	NP LANGSTON	406	406	0	406	90.08
90.09	09008	OP NURSING SERVICE	490	490	0	490	90.09
90.10	09009	DR. RAJU	0	0	0	0	90.10
91.00	09100	EMERGENCY	2,733	2,733	0	37,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,457	66,837	1,620	374,083	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	455	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	150	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	112	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	28,703	192.03
192.04	19204	6TH STREET HOURSE	0	0	0	0	192.04
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)	1,251,982	611,002	3,949	369,407	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.288590	9.141673	2.437654	0.916534	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	336,791	4,461	29	40,341	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.919745	0.066744	0.017901	0.100090	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	7.00	7.01	7.02	8.00	9.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY					7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	50,830				10.00
11.00	01100	CAFETERIA	0	12,062			11.00
13.00	01300	NURSING ADMINISTRATION	0	89	4,278		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	206	0	567,908	14.00
15.00	01500	PHARMACY	0	229	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	704	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,065	2,113	2,113	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4	2	2	0	31.00
44.00	04400	SKILLED NURSING FACILITY	38,761	3,316	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	828	828	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	658	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	160	0	0	55.00
60.00	06000	LABORATORY	0	1,310	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	307	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	628	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	89	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	88	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	273,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	294,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	1,335	1,335	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,830	12,062	4,278	567,908	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	192.03
192.04	19204	6TH STREET HOUSE	0	0	0	0	192.04
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)	1,037,246	263,335	286,861	233,191	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.406177	21.831786	67.054932	0.410614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,473	1,960	10,869	13,517	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.484812	0.162494	2.540673	0.023801	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATIO N (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
		10.00	11.00	13.00	14.00	15.00	
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: 14-1346

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		85,284,981	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		5,393,831	
		4,190	
		2,387,605	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		3,722,595	
		0	
		17,232,961	
		699,393	
		20,596,782	
		2,103,234	
		2,797,433	
		448,920	
		248,613	
		2,844,232	
		1,251,944	
		9,855,799	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
90.01	09002	WOUND CARE	90.01
90.02	09003	PAIN MANAGEMENT	90.02
90.03	09001	NEUROLOGY	90.03
90.04	09004	DR SKOW	90.04
90.05	09005	DR BLASER	90.05
90.06	09006	DR. RONHOLM	90.06
90.07	09007	DR. BARKOVIK	90.07
90.08	04950	NP LANGSTON	90.08
90.09	09008	OP NURSING SERVICE	90.09
90.10	09009	DR. RAJU	90.10
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
		1,188,264	
		143,379	
		1,918,818	
		1,425,951	
		63,205	
		0	
		120,836	
		702,206	
		63,443	
		97,760	
		83,192	
		540,816	
		0	
		9,349,579	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
		0	
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		85,284,981	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FAYETTE COUNTY ANNEX	192.01
192.02	19202	PUBLIC RELATIONS	192.02
192.03	19203	PERSONAL LAUNDRY	192.03
192.04	19204	6TH STREET HOUSE	192.04
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
		1,168,553	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.013702	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		20,981	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000246	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 8:34 am

			Title XVIII		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,619,907		3,619,907	0	3,619,907
31.00	03100	INTENSIVE CARE UNIT	36,348		36,348	0	36,348
44.00	04400	SKILLED NURSING FACILITY	5,081,930		5,081,930	0	5,081,930
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,073,489		2,073,489	0	2,073,489
53.00	05300	ANESTHESIOLOGY	0		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,180,847		2,180,847	0	2,180,847
55.00	05500	RADIOLOGY-THERAPEUTIC	414,620		414,620	0	414,620
60.00	06000	LABORATORY	4,551,775		4,551,775	0	4,551,775
65.00	06500	RESPIRATORY THERAPY	513,646	0	513,646	0	513,646
66.00	06600	PHYSICAL THERAPY	1,194,427	0	1,194,427	0	1,194,427
67.00	06700	OCCUPATIONAL THERAPY	166,173	0	166,173	0	166,173
68.00	06800	SPEECH PATHOLOGY	169,271	0	169,271	0	169,271
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	470,513		470,513	0	470,513
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	480,932		480,932	0	480,932
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131,111		3,131,111	0	3,131,111
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,759,867		1,759,867	0	1,759,867
88.01	08801	RURAL HEALTH CLINIC II	294,256		294,256	0	294,256
90.00	09000	CLINIC	796,009		796,009	0	796,009
90.01	09002	WOUND CARE	431,687		431,687	0	431,687
90.02	09003	PAIN MANAGEMENT	70,111		70,111	0	70,111
90.03	09001	NEUROLOGY	0		0	0	0
90.04	09004	DR SKOW	611,868		611,868	0	611,868
90.05	09005	DR BLASER	956,802		956,802	0	956,802
90.06	09006	DR. RONHOLM	83,904		83,904	0	83,904
90.07	09007	DR. BARKOVIK	74,221		74,221	0	74,221
90.08	04950	NP LANGSTON	63,957		63,957	0	63,957
90.09	09008	OP NURSING SERVICE	210,560		210,560	0	210,560
90.10	09009	DR. RAJU	67,526		67,526	0	67,526
91.00	09100	EMERGENCY	4,333,505		4,333,505	0	4,333,505
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	367,739		367,739		367,739
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	34,207,001	0	34,207,001	0	34,207,001
201.00		Less Observation Beds	367,739		367,739		367,739
202.00		Total (see instructions)	33,839,262	0	33,839,262	0	33,839,262

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/30/2021 8:34 am	
			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,190,202		4,190,202			30.00
31.00	03100	INTENSIVE CARE UNIT	4,190		4,190			31.00
44.00	04400	SKILLED NURSING FACILITY	2,387,605		2,387,605			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	282,888	3,439,707	3,722,595	0.557001	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,044,668	16,188,293	17,232,961	0.126551	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	48,680	650,713	699,393	0.592828	0.000000	55.00
60.00	06000	LABORATORY	2,118,203	18,478,579	20,596,782	0.220994	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	679,089	1,424,145	2,103,234	0.244217	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	578,833	2,218,600	2,797,433	0.426973	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,278	265,642	448,920	0.370162	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,813	165,800	248,613	0.680861	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,466,293	1,377,939	2,844,232	0.165427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,061,118	190,826	1,251,944	0.384148	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,034,803	6,820,996	9,855,799	0.317692	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	359	1,187,905	1,188,264			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	143,379	143,379			88.01
90.00	09000	CLINIC	0	1,918,818	1,918,818	0.414843	0.000000	90.00
90.01	09002	WOUND CARE	0	1,425,951	1,425,951	0.302736	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	63,205	63,205	1.109264	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	0.000000	90.03
90.04	09004	DR SKOW	5,788	115,048	120,836	5.063623	0.000000	90.04
90.05	09005	DR BLASER	30,728	671,478	702,206	1.362566	0.000000	90.05
90.06	09006	DR. RONHOLM	0	63,443	63,443	1.322510	0.000000	90.06
90.07	09007	DR. BARKOVIK	6,425	91,335	97,760	0.759216	0.000000	90.07
90.08	04950	NP LANGSTON	37,478	45,714	83,192	0.768788	0.000000	90.08
90.09	09008	OP NURSING SERVICE	1,657	539,159	540,816	0.389338	0.000000	90.09
90.10	09009	DR. RAJU	0	0	0	0.000000	0.000000	90.10
91.00	09100	EMERGENCY	3,000	9,346,579	9,349,579	0.463497	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,891	1,196,738	1,203,629	0.305525	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,254,989	68,029,992	85,284,981			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,254,989	68,029,992	85,284,981			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN:14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 8:34 am
			Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.557001		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828		55.00
60.00	06000	LABORATORY	0.220994		60.00
65.00	06500	RESPIRATORY THERAPY	0.244217		65.00
66.00	06600	PHYSICAL THERAPY	0.426973		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370162		67.00
68.00	06800	SPEECH PATHOLOGY	0.680861		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.414843		90.00
90.01	09002	WOUND CARE	0.302736		90.01
90.02	09003	PAIN MANAGEMENT	1.109264		90.02
90.03	09001	NEUROLOGY	0.000000		90.03
90.04	09004	DR SKOW	5.063623		90.04
90.05	09005	DR BLASER	1.362566		90.05
90.06	09006	DR. RONHOLM	1.322510		90.06
90.07	09007	DR. BARKOVIK	0.759216		90.07
90.08	04950	NP LANGSTON	0.768788		90.08
90.09	09008	OP NURSING SERVICE	0.389338		90.09
90.10	09009	DR. RAJU	0.000000		90.10
91.00	09100	EMERGENCY	0.463497		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 8:34 am

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,619,907		3,619,907	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	36,348		36,348	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	5,081,930		5,081,930	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,073,489		2,073,489	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,180,847		2,180,847	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	414,620		414,620	0	0 55.00
60.00	06000	LABORATORY	4,551,775		4,551,775	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	513,646	0	513,646	0	0 65.00
66.00	06600	PHYSICAL THERAPY	1,194,427	0	1,194,427	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	166,173	0	166,173	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	169,271	0	169,271	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	470,513		470,513	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	480,932		480,932	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131,111		3,131,111	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,759,867		1,759,867	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	294,256		294,256	0	0 88.01
90.00	09000	CLINIC	796,009		796,009	0	0 90.00
90.01	09002	WOUND CARE	431,687		431,687	0	0 90.01
90.02	09003	PAIN MANAGEMENT	70,111		70,111	0	0 90.02
90.03	09001	NEUROLOGY	0		0	0	0 90.03
90.04	09004	DR SKOW	611,868		611,868	0	0 90.04
90.05	09005	DR BLASER	956,802		956,802	0	0 90.05
90.06	09006	DR. RONHOLM	83,904		83,904	0	0 90.06
90.07	09007	DR. BARKOVIK	74,221		74,221	0	0 90.07
90.08	04950	NP LANGSTON	63,957		63,957	0	0 90.08
90.09	09008	OP NURSING SERVICE	210,560		210,560	0	0 90.09
90.10	09009	DR. RAJU	67,526		67,526	0	0 90.10
91.00	09100	EMERGENCY	4,333,505		4,333,505	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	367,739		367,739	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	34,207,001	0	34,207,001	0	0 200.00
201.00		Less Observation Beds	367,739		367,739		0 201.00
202.00		Total (see instructions)	33,839,262	0	33,839,262	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 8:34 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,153,509		4,153,509		30.00
31.00	03100	INTENSIVE CARE UNIT	12,728		12,728		31.00
44.00	04400	SKILLED NURSING FACILITY	2,387,605		2,387,605		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	289,731	3,233,732	3,523,463	0.588480	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,044,668	16,188,293	17,232,961	0.126551	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	48,680	650,713	699,393	0.592828	55.00
60.00	06000	LABORATORY	2,105,602	18,390,877	20,496,479	0.222076	60.00
65.00	06500	RESPIRATORY THERAPY	678,486	1,411,726	2,090,212	0.245739	65.00
66.00	06600	PHYSICAL THERAPY	578,833	2,218,600	2,797,433	0.426973	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,278	265,642	448,920	0.370162	67.00
68.00	06800	SPEECH PATHOLOGY	82,813	165,800	248,613	0.680861	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,466,293	1,377,939	2,844,232	0.165427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,061,118	190,826	1,251,944	0.384148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,034,803	6,820,996	9,855,799	0.317692	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	359	1,187,905	1,188,264	1.481040	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	143,379	143,379	2.052295	88.01
90.00	09000	CLINIC	0	1,918,818	1,918,818	0.414843	90.00
90.01	09002	WOUND CARE	0	1,306,721	1,306,721	0.330359	90.01
90.02	09003	PAIN MANAGEMENT	0	35,042	35,042	2.000771	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	90.03
90.04	09004	DR SKOW	0	73,262	73,262	8.351779	90.04
90.05	09005	DR BLASER	0	45,670	45,670	20.950339	90.05
90.06	09006	DR. RONHOLM	0	62,709	62,709	1.337990	90.06
90.07	09007	DR. BARKOVIK	0	83,595	83,595	0.887864	90.07
90.08	04950	NP LANGSTON	0	28,218	28,218	2.266532	90.08
90.09	09008	OP NURSING SERVICE	0	522,520	522,520	0.402970	90.09
90.10	09009	DR. RAJU	0	0	0	0.000000	90.10
91.00	09100	EMERGENCY	0	8,885,722	8,885,722	0.487693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,891	1,196,738	1,203,629	0.305525	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	17,135,397	66,405,443	83,540,840		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	17,135,397	66,405,443	83,540,840		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	WOUND CARE	0.000000			90.01
90.02	09003	PAIN MANAGEMENT	0.000000			90.02
90.03	09001	NEUROLOGY	0.000000			90.03
90.04	09004	DR SKOW	0.000000			90.04
90.05	09005	DR BLASER	0.000000			90.05
90.06	09006	DR. RONHOLM	0.000000			90.06
90.07	09007	DR. BARKOVIK	0.000000			90.07
90.08	04950	NP LANGSTON	0.000000			90.08
90.09	09008	OP NURSING SERVICE	0.000000			90.09
90.10	09009	DR. RAJU	0.000000			90.10
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	315,187	3,722,595	0.084669	207,599	17,577	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	148,623	17,232,961	0.008624	559,403	4,824	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,162	699,393	0.004521	32,055	145	55.00
60.00	06000 LABORATORY	133,298	20,596,782	0.006472	1,023,042	6,621	60.00
65.00	06500 RESPIRATORY THERAPY	25,065	2,103,234	0.011917	353,416	4,212	65.00
66.00	06600 PHYSICAL THERAPY	41,748	2,797,433	0.014924	123,095	1,837	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,333	448,920	0.007424	31,511	234	67.00
68.00	06800 SPEECH PATHOLOGY	1,299	248,613	0.005225	20,336	106	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,545	2,844,232	0.003356	752,150	2,524	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,814	1,251,944	0.007839	872,627	6,841	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,682	9,855,799	0.004026	1,339,520	5,393	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	15,204	1,188,264	0.012795	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	2,206	143,379	0.015386	0	0	88.01
90.00	09000 CLINIC	27,191	1,918,818	0.014171	0	0	90.00
90.01	09002 WOUND CARE	6,055	1,425,951	0.004246	0	0	90.01
90.02	09003 PAIN MANAGEMENT	3,219	63,205	0.050930	0	0	90.02
90.03	09001 NEUROLOGY	0	0	0.000000	0	0	90.03
90.04	09004 DR SKOW	18,449	120,836	0.152678	0	0	90.04
90.05	09005 DR BLASER	18,731	702,206	0.026675	0	0	90.05
90.06	09006 DR. RONHOLM	3,322	63,443	0.052362	0	0	90.06
90.07	09007 DR. BARKOVIK	3,254	97,760	0.033286	0	0	90.07
90.08	04950 NP LANGSTON	5,363	83,192	0.064465	0	0	90.08
90.09	09008 OP NURSING SERVICE	7,519	540,816	0.013903	0	0	90.09
90.10	09009 DR. RAJU	503	0	0.000000	0	0	90.10
91.00	09100 EMERGENCY	82,753	9,349,579	0.008851	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	14,247	1,203,629	0.011837	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	938,772	78,702,984		5,314,754	50,314	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
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: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 8:34 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	3,722,595	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	17,232,961	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	699,393	0.000000	55.00
60.00	06000	LABORATORY		0	0	0	20,596,782	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,103,234	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,797,433	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	448,920	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	248,613	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	2,844,232	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	1,251,944	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	9,855,799	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,188,264	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	143,379	0.000000	88.01
90.00	09000	CLINIC		0	0	0	1,918,818	0.000000	90.00
90.01	09002	WOUND CARE		0	0	0	1,425,951	0.000000	90.01
90.02	09003	PAIN MANAGEMENT		0	0	0	63,205	0.000000	90.02
90.03	09001	NEUROLOGY		0	0	0	0	0.000000	90.03
90.04	09004	DR SKOW		0	0	0	120,836	0.000000	90.04
90.05	09005	DR BLASER		0	0	0	702,206	0.000000	90.05
90.06	09006	DR. RONHOLM		0	0	0	63,443	0.000000	90.06
90.07	09007	DR. BARKOVIK		0	0	0	97,760	0.000000	90.07
90.08	04950	NP LANGSTON		0	0	0	83,192	0.000000	90.08
90.09	09008	OP NURSING SERVICE		0	0	0	540,816	0.000000	90.09
90.10	09009	DR. RAJU		0	0	0	0	0.000000	90.10
91.00	09100	EMERGENCY		0	0	0	9,349,579	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,203,629	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0			95.00
200.00		Total (lines 50 through 199)		0	0	0	78,702,984		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 8:34 am

				Title XVIII		Hospital	Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	207,599	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	559,403	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	32,055	0	0	0
60.00	06000	LABORATORY		0.000000	1,023,042	0	0	0
65.00	06500	RESPIRATORY THERAPY		0.000000	353,416	0	0	0
66.00	06600	PHYSICAL THERAPY		0.000000	123,095	0	0	0
67.00	06700	OCCUPATIONAL THERAPY		0.000000	31,511	0	0	0
68.00	06800	SPEECH PATHOLOGY		0.000000	20,336	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	752,150	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	872,627	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,339,520	0	0	0
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0
90.00	09000	CLINIC		0.000000	0	0	0	0
90.01	09002	WOUND CARE		0.000000	0	0	0	0
90.02	09003	PAIN MANAGEMENT		0.000000	0	0	0	0
90.03	09001	NEUROLOGY		0.000000	0	0	0	0
90.04	09004	DR. SKOW		0.000000	0	0	0	0
90.05	09005	DR. BLASER		0.000000	0	0	0	0
90.06	09006	DR. RONHOLM		0.000000	0	0	0	0
90.07	09007	DR. BARKOVIK		0.000000	0	0	0	0
90.08	04950	NP LANGSTON		0.000000	0	0	0	0
90.09	09008	OP NURSING SERVICE		0.000000	0	0	0	0
90.10	09009	DR. RAJU		0.000000	0	0	0	0
91.00	09100	EMERGENCY		0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						
200.00		Total (lines 50 through 199)			5,314,754	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
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			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	0.557001	0	1,463,732	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551	0	6,524,353	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828	0	243,951	0	0	55.00
60.00	06000	LABORATORY	0.220994	0	7,558,360	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.244217	0	658,260	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.426973	0	829,481	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370162	0	110,024	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.680861	0	48,607	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427	0	301,083	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148	0	83,536	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692	0	3,614,947	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.414843	0	1,898,507	0	0	90.00
90.01	09002	WOUND CARE	0.302736	0	715,779	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.109264	0	14,958	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	5.063623	0	23,022	0	0	90.04
90.05	09005	DR BLASER	1.362566	0	35,686	0	0	90.05
90.06	09006	DR. RONHOLM	1.322510	0	12,096	0	0	90.06
90.07	09007	DR. BARKOVIK	0.759216	0	28,809	0	0	90.07
90.08	04950	NP LANGSTON	0.768788	0	17,967	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.389338	0	0	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	0	0	90.10
91.00	09100	EMERGENCY	0.463497	0	2,506,154	850	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525	0	631,987	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	27,321,299	850	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,321,299	850	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 8:34 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	815,300	0				50.00	
53.00	05300	ANESTHESIOLOGY	0	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	825,663	0				54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	144,621	0				55.00	
60.00	06000	LABORATORY	1,670,352	0				60.00	
65.00	06500	RESPIRATORY THERAPY	160,758	0				65.00	
66.00	06600	PHYSICAL THERAPY	354,166	0				66.00	
67.00	06700	OCCUPATIONAL THERAPY	40,727	0				67.00	
68.00	06800	SPEECH PATHOLOGY	33,095	0				68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,807	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	32,090	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,148,440	0				73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
88.01	08801	RURAL HEALTH CLINIC II						88.01	
90.00	09000	CLINIC	787,582	0				90.00	
90.01	09002	WOUND CARE	216,692	0				90.01	
90.02	09003	PAIN MANAGEMENT	16,592	0				90.02	
90.03	09001	NEUROLOGY	0	0				90.03	
90.04	09004	DR SKOW	116,575	0				90.04	
90.05	09005	DR BLASER	48,625	0				90.05	
90.06	09006	DR. RONHOLM	15,997	0				90.06	
90.07	09007	DR. BARKOVIK	21,872	0				90.07	
90.08	04950	NP LANGSTON	13,813	0				90.08	
90.09	09008	OP NURSING SERVICE	0	0				90.09	
90.10	09009	DR. RAJU	0	0				90.10	
91.00	09100	EMERGENCY	1,161,595	394				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,088	0				92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0					95.00	
200.00		Subtotal (see instructions)	7,867,450	394				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	7,867,450	394				202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet D
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11/30/2021 8:34 am

			Title XIX		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.588480	0	69,428	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551	0	440,757	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828	0	14,536	0	0	55.00
60.00	06000	LABORATORY	0.222076	0	348,742	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.245739	0	42,522	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.426973	0	58,776	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370162	0	2,398	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.680861	0	12,142	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427	0	25,240	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692	0	72,777	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.414843	0	349	0	0	90.00
90.01	09002	WOUND CARE	0.330359	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	2.000771	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	8.351779	0	0	0	0	90.04
90.05	09005	DR BLASER	20.950339	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	1.337990	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0.887864	0	0	0	0	90.07
90.08	04950	NP LANGSTON	2.266532	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.402970	0	0	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	0	0	90.10
91.00	09100	EMERGENCY	0.487693	0	343,674	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525	0	34,464	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,465,805	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,465,805	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
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			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
			ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	40,857	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,778	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,617	0		55.00
60.00	06000	LABORATORY	77,447	0		60.00
65.00	06500	RESPIRATORY THERAPY	10,449	0		65.00
66.00	06600	PHYSICAL THERAPY	25,096	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	888	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,267	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,175	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,121	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	145	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
90.06	09006	DR. RONHOLM	0	0		90.06
90.07	09007	DR. BARKOVIK	0	0		90.07
90.08	04950	NP LANGSTON	0	0		90.08
90.09	09008	OP NURSING SERVICE	0	0		90.09
90.10	09009	DR. RAJU	0	0		90.10
91.00	09100	EMERGENCY	167,607	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,530	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	432,977	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	432,977	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
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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)	4,151	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,512	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)	2,104	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	760	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)	713	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	83	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)	83	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,355	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)	760	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)	713	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)	3,619,907	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)	14,086	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)	14,086	25.00
26.00	Total swing-bed cost (see instructions)	1,355,802	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,264,105	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,264,105	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)	901.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,221,275	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)	1,221,275	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	36,348	4	9,087.00	2	18,174	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)					1,481,092	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,720,541	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					684,996	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					642,634	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,327,630	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					408	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					901.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					367,739	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

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		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	140,243	3,619,907	0.038742	367,739	14,247
91.00	Nursing School cost	0	3,619,907	0.000000	367,739	0
92.00	Allied health cost	0	3,619,907	0.000000	367,739	0
93.00	All other Medical Education	0	3,619,907	0.000000	367,739	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 8:34 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,935	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,935	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)		12,935	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		5,081,930	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)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,081,930	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)		5,081,930	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 8:34 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					5,081,930	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					392.88	71.00
72.00 Program routine service cost (line 9 x line 71)					0	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1346 Component CCN:14-5499		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/30/2021 8:34 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 8:34 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,151	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,512	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)			2,104	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			760	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)			713	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			83	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)			83	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			31	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,619,907	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)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			1,338,044	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,281,863	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,281,863	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)			908.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			28,160	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)			28,160	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	36,348	4	9,087.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					23,550	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					51,710	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					408	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					908.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					370,619	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/30/2021 8:34 am	
		Title XIX		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	140,243	3,619,907	0.038742	370,619	14,359	90.00
91.00	Nursing School cost	0	3,619,907	0.000000	370,619	0	91.00
92.00	Allied health cost	0	3,619,907	0.000000	370,619	0	92.00
93.00	All other Medical Education	0	3,619,907	0.000000	370,619	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 8:34 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,901,043		30.00
31.00	03100	INTENSIVE CARE UNIT		4,190		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.557001	207,599	115,633	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551	559,403	70,793	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828	32,055	19,003	55.00
60.00	06000	LABORATORY	0.220994	1,023,042	226,086	60.00
65.00	06500	RESPIRATORY THERAPY	0.244217	353,416	86,310	65.00
66.00	06600	PHYSICAL THERAPY	0.426973	123,095	52,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370162	31,511	11,664	67.00
68.00	06800	SPEECH PATHOLOGY	0.680861	20,336	13,846	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427	752,150	124,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148	872,627	335,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692	1,339,520	425,555	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.414843	0	0	90.00
90.01	09002	WOUND CARE	0.302736	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.109264	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR. SKOW	5.063623	0	0	90.04
90.05	09005	DR. BLASER	1.362566	0	0	90.05
90.06	09006	DR. RONHOLM	1.322510	0	0	90.06
90.07	09007	DR. BARKOVIK	0.759216	0	0	90.07
90.08	04950	NP LANGSTON	0.768788	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.389338	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	90.10
91.00	09100	EMERGENCY	0.463497	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,314,754	1,481,092	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,314,754		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3
			Component CCN: 14-Z346		Date/Time Prepared: 11/30/2021 8:34 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.557001	30,603	17,046
53.00	05300	ANESTHESIOLOGY	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551	179,678	22,738
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828	2,547	1,510
60.00	06000	LABORATORY	0.220994	539,335	119,190
65.00	06500	RESPIRATORY THERAPY	0.244217	107,114	26,159
66.00	06600	PHYSICAL THERAPY	0.426973	374,499	159,901
67.00	06700	OCCUPATIONAL THERAPY	0.370162	122,407	45,310
68.00	06800	SPEECH PATHOLOGY	0.680861	48,416	32,965
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427	305,438	50,528
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692	707,206	224,674
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0
90.00	09000	CLINIC	0.414843	0	0
90.01	09002	WOUND CARE	0.302736	0	0
90.02	09003	PAIN MANAGEMENT	1.109264	0	0
90.03	09001	NEUROLOGY	0.000000	0	0
90.04	09004	DR SKOW	5.063623	0	0
90.05	09005	DR BLASER	1.362566	0	0
90.06	09006	DR. RONHOLM	1.322510	0	0
90.07	09007	DR. BARKOVIK	0.759216	0	0
90.08	04950	NP LANGSTON	0.768788	0	0
90.09	09008	OP NURSING SERVICE	0.389338	0	0
90.10	09009	DR. RAJU	0.000000	0	0
91.00	09100	EMERGENCY	0.463497	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,417,243	700,021
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		2,417,243	700,021

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 8:34 am	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		39,713		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.588480	1,922	1,131	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126551	7,878	997	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.592828	2,236	1,326	55.00
60.00	06000	LABORATORY	0.222076	20,114	4,467	60.00
65.00	06500	RESPIRATORY THERAPY	0.245739	8,750	2,150	65.00
66.00	06600	PHYSICAL THERAPY	0.426973	316	135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.370162	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.680861	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165427	13,126	2,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317692	35,169	11,173	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.481040	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.052295	0	0	88.01
90.00	09000	CLINIC	0.414843	0	0	90.00
90.01	09002	WOUND CARE	0.330359	0	0	90.01
90.02	09003	PAIN MANAGEMENT	2.000771	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	90.03
90.04	09004	DR. SKOW	8.351779	0	0	90.04
90.05	09005	DR. BLASER	20.950339	0	0	90.05
90.06	09006	DR. RONHOLM	1.337990	0	0	90.06
90.07	09007	DR. BARKOVIK	0.887864	0	0	90.07
90.08	04950	NP LANGSTON	2.266532	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.402970	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	90.10
91.00	09100	EMERGENCY	0.487693	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.305525	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		89,511	23,550	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		89,511		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 8:34 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,867,844
2.00	Medical and other services reimbursed under OPPS (see instructions)			0
3.00	OPPS payments			0
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,867,844
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			0
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			0
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			7,946,522
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			71,595
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,024,173
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,850,754
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			3,850,754
31.00	Primary payer payments			818
32.00	Subtotal (line 30 minus line 31)			3,849,936
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			1,044,651
35.00	Adjusted reimbursable bad debts (see instructions)			679,023
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			770,519
37.00	Subtotal (see instructions)			4,528,959
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			4,528,959
40.01	Sequestration adjustment (see instructions)			0
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			5,636,705
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			-1,107,746
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 8:34 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,051,127		4,840,605	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	11/30/2020	97,300	11/30/2020	217,600	3.01
3.02			0	02/11/2021	578,500	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)		97,300		796,100	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)		2,148,427		5,636,705	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		326,661		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,107,746	6.02
7.00	Total Medicare program liability (see instructions)		2,475,088		4,528,959	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: 14-1346

Period:

Worksheet E-1

Component CCN: 14-Z346

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 8:34 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,891,453		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	11/30/2020	91,500		0	3.01
3.02		02/11/2021	138,100		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)		229,600		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)		2,121,053		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		100,386		0	6.02
7.00	Total Medicare program liability (see instructions)		2,020,667		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: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 8:34 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1346

Period:

Worksheet E-2

Component CCN: 14-Z346

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,340,906	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)		707,021	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		1,473	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)		2,047,927	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,047,927	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)		2,047,927	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		27,260	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,020,667	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,020,667	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		2,121,053	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)		-100,386	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/30/2021 8:34 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,720,541	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,720,541	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,747,746	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,747,746	19.00
20.00	Deductibles (exclude professional component)		361,236	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,386,510	22.00
23.00	Coinsurance		352	23.00
24.00	Subtotal (line 22 minus line 23)		2,386,158	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		136,815	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		88,930	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		93,004	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,475,088	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)		2,475,088	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		2,148,427	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)		326,661	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1346 Component CCN:14-5499	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2021 8:34 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 8:34 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		51,710		1.00
2.00	Medical and other services			432,977	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		52,227	437,307	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		52,227	437,307	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		39,713		8.00
9.00	Ancillary service charges		89,511	1,465,805	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		129,224	1,465,805	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		129,224	1,465,805	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		76,997	1,028,498	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		52,227	437,307	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		52,227	437,307	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		52,227	437,307	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		52,227	437,307	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		52,227	437,307	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		52,227	437,307	40.00
41.00	Interim payments		32,137	492,569	41.00
42.00	Balance due provider/program (line 40 minus line 41)		20,090	-55,262	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 8:34 am
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1346

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

Worksheet G

Date/Time Prepared:
11/30/2021 8:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,106,416	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,199,942	0	0	0	4.00
5.00	Other receivable	4,965	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,954,459	0	0	0	6.00
7.00	Inventory	380,042	0	0	0	7.00
8.00	Prepaid expenses	245,049	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	279,333	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,261,288	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	6,618,047	0	0	0	23.00
24.00	Accumulated depreciation	-4,744,068	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,898,111	0	0	0	27.00
28.00	Accumulated depreciation	-1,898,111	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,873,979	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	331,598	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	331,598	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,466,865	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	413,247	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,584,687	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,267,824	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,265,758	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	943,200	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	943,200	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,208,958	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,257,907				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,257,907	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,466,865	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1346

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 8:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		2,655,912		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,601,995				2.00
3.00	Total (sum of line 1 and line 2)		4,257,907		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)		4,257,907		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)		4,257,907		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: 14-1346

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 8:34 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,409,819		4,409,819	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,387,605		2,387,605	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)	6,797,424		6,797,424	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	60,290		60,290	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)	60,290		60,290	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,857,714		6,857,714	17.00
18.00	Ancillary services	10,738,114	53,826,686	64,564,800	18.00
19.00	Outpatient services	712	11,252,662	11,253,374	19.00
20.00	RURAL HEALTH CLINIC	359	1,331,396	1,331,755	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CLINIC	0	1,918,818	1,918,818	27.00
27.01	WOUND CARE	0	1,639,700	1,639,700	27.01
27.02	PAIN MANAGEMENT	0	261,062	261,062	27.02
27.03	NEUROLOGY	0	0	0	27.03
27.04	DR SKOW	30,973	311,429	342,402	27.04
27.05	DR BLASER	95,872	3,208,334	3,304,206	27.05
27.06	DR RONHOLM	0	95,910	95,910	27.06
27.07	DR BARKOVIK	5,446	161,610	167,056	27.07
27.08	NP DIEDRE	313,135	169,296	482,431	27.08
27.09	OBSERVATION	6,891	1,212,955	1,219,846	27.09
27.10	AMBULANCE SERVICES	0	0	0	27.10
27.11	PHYSICIAN REVENUE	41,900	1,134,631	1,176,531	27.11
27.12	OTHER OUTPATIENT	0	0	0	27.12
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,091,116	76,524,489	94,615,605	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,932,926		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,932,926		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1346

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

Worksheet G-3

Date/Time Prepared:
11/30/2021 8:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	94,615,605	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,077,503	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,538,102	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,932,926	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,394,824	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	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	89,330	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	35	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	597	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,090,865	24.00
24.50	COVID-19 PHE Funding	1,815,992	24.50
25.00	Total other income (sum of lines 6-24)	3,996,819	25.00
26.00	Total (line 5 plus line 25)	1,601,995	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,601,995	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8527

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	287,938	0	287,938	0	287,938
2.00	Physician Assistant	107,412	0	107,412	0	107,412
3.00	Nurse Practitioner	231,261	0	231,261	0	231,261
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	100,287	0	100,287	0	100,287
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	47,001	0	47,001	0	47,001
10.00	Subtotal (sum of lines 1 through 9)	773,899	0	773,899	0	773,899
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	204	204	0	204
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	204	204	0	204
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	773,899	204	774,103	0	774,103
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	569	569	0	569
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	569	569	0	569
FACILITY OVERHEAD						
29.00	Facility Costs	0	39,427	39,427	0	39,427
30.00	Administrative Costs	141,074	110,252	251,326	-28,843	222,483
31.00	Total Facility Overhead (sum of lines 29 and 30)	141,074	149,679	290,753	-28,843	261,910
32.00	Total facility costs (sum of lines 22, 28 and 31)	914,973	150,452	1,065,425	-28,843	1,036,582

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8527

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	287,938	1.00
2.00	Physician Assistant	0	107,412	2.00
3.00	Nurse Practitioner	0	231,261	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	100,287	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	47,001	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	773,899	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	204	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	204	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	774,103	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	569	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	569	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	39,427	29.00
30.00	Administrative Costs	-275	222,208	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-275	261,635	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-275	1,036,307	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8528

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	43,903	0	43,903	0	43,903
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	50,655	0	50,655	0	50,655
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)	94,558	0	94,558	0	94,558
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	23	23	0	23
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	23	23	0	23
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	94,558	23	94,581	0	94,581
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	131	131	0	131
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	131	131	0	131
FACILITY OVERHEAD						
29.00	Facility Costs	0	39,515	39,515	0	39,515
30.00	Administrative Costs	20,803	28,952	49,755	4,743	54,498
31.00	Total Facility Overhead (sum of lines 29 and 30)	20,803	68,467	89,270	4,743	94,013
32.00	Total facility costs (sum of lines 22, 28 and 31)	115,361	68,621	183,982	4,743	188,725

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8528

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	43,903	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	50,655	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	94,558	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	23	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	23	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	94,581	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	131	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	131	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	39,515	29.00
30.00	Administrative Costs	0	54,498	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	94,013	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	188,725	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346

Period:

Worksheet M-2

Component CCN: 14-8527

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC I		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.88	1,737	1	1
2.00	Physician Assistant	0.61	1,502	1	1
3.00	Nurse Practitioner	1.76	3,679	1	2
4.00	Subtotal (sum of lines 1 through 3)	3.25	6,918		4
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.25	6,918		6,918
9.00	Physician Services Under Agreements		0		0
					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)				774,103
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				569
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				774,672
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999265
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				261,635
15.00	Parent provider overhead allocated to facility (see instructions)				723,560
16.00	Total overhead (sum of lines 14 and 15)				985,195
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				985,195
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				984,471
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,758,574

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346

Period:

Worksheet M-2

Component CCN: 14-8528

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 8:34 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.00	0	1	0
2.00	Physician Assistant	0.30	834	1	0
3.00	Nurse Practitioner	0.00	0	1	0
4.00	Subtotal (sum of lines 1 through 3)	0.30	834	0	834
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.30	834		834
9.00	Physician Services Under Agreements		0		0
					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)				94,581
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				131
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				94,712
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998617
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				94,013
15.00	Parent provider overhead allocated to facility (see instructions)				105,531
16.00	Total overhead (sum of lines 14 and 15)				199,544
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				199,544
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				199,268
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				293,849

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/30/2021 8:34 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,758,574	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,758,574	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,918	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,918	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			254.20	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)	257.14	168.42	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	254.20	254.20	0.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	877	767	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	222,933	194,971	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	417,904		16.00
16.01	Total program charges (see instructions)(from contractor's records)		319,370		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		42,965		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		56,221		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.)		261,971		16.04
16.05	Total program cost (see instructions)	0	318,192		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,219		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,438		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		318,192		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		318,192		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		318,192		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		309,396		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		8,796		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:14-1346 Component CCN:14-8528	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/30/2021 8:34 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			293,849	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			293,849	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			834	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)			834	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			352.34	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)	457.08	225.68	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	352.34	352.34	0.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	121	130	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	42,633	45,804	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	88,437		16.00
16.01	Total program charges (see instructions)(from contractor's records)		50,701		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,586		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,976		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.)		53,443		16.04
16.05	Total program cost (see instructions)	0	68,419		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,657		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,092		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		68,419		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		68,419		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		68,419		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		85,418		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-16,999		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/30/2021 8:34 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		250,796	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		02/11/2021	58,600	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)		58,600	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		309,396	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		8,796	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		318,192	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: 14-1346 Component CCN: 14-8528	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/30/2021 8:34 am	
		RHC II	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		55,518	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		02/11/2021	29,900	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)		29,900	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		85,418	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		16,999	6.02	
7.00	Total Medicare program liability (see instructions)		68,419	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00