

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: 14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 2:49 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/23/2021	Time: 2:49 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (14-1349) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	142,279	-86,892	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	104,470	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		480,543		0	10.00
200.00	Total	0	246,749	393,651	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 818 EAST BROADWAY			PO Box:				1.00		
2.00	City: SPARTA			State: IL		Zip Code: 62286		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	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		
21.00	Type of Control (see instructions)						11			
							1.00	2.00		
							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			
22.01	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			
22.02	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			
22.03	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		
22.04	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.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr			
					1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:			
					1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N			
					1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					V	XVIII	XIX		
					1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N							57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

			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)	N	N	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)	N	N	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)	N	N	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		N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	Y	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	473,452	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.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			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: 14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 2:49 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 2:49 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	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)	Y	09/23/2021	Y	09/23/2021		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)	N		N			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: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/23/2021 2:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	21,222.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	21,222.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	21,222.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	527	7	872		1.00
2.00	HMO and other (see instructions)	130	0			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	598	0	769		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	39		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,125	7	1,680		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,125	7	1,680	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	6,204	0	13,787	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			21		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	10,881	0	42,772	0.00	26.00
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	610		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			19		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: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	154	2	265	1.00
2.00 HMO and other (see instructions)			34	0		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	154	2	265	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-7694		Period: From 07/01/2020 To 06/30/2021		Worksheet S-4 Date/Time Prepared: 11/23/2021 2:49 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	326.00	78.00	378.00	782.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.35	0.00	2.35	4.00
5.00	Other Administrative Personnel			0.08	0.00	0.08	5.00
6.00	Direct Nursing Service			9.72	0.00	9.72	6.00
7.00	Nursing Supervisor			1.20	0.00	1.20	7.00
8.00	Physical Therapy Service			3.94	0.00	3.94	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.53	0.00	0.53	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.07	0.07	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16060			20.00
20.01				41180			20.01
20.02				99913			20.02
20.03				99914			20.03
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,978	227	63	0	3,268	21.00
22.00	Skilled Nursing Visit Charges	1,016,318	78,066	21,430	0	1,115,814	22.00
23.00	Physical Therapy Visits	2,249	406	2	0	2,657	23.00
24.00	Physical Therapy Visit Charges	626,811	110,135	696	0	737,642	24.00
25.00	Occupational Therapy Visits	134	109	0	0	243	25.00
26.00	Occupational Therapy Visit Charges	44,699	37,351	0	0	82,050	26.00
27.00	Speech Pathology Visits	15	21	0	0	36	27.00
28.00	Speech Pathology Visit Charges	5,156	7,219	0	0	12,375	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,376	763	65	0	6,204	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,692,984	232,771	22,126	0	1,947,881	35.00
36.00	Total Number of Episodes (standard/non outlier)	555		46	0	601	36.00
37.00	Total Number of Outlier Episodes		38		0	38	37.00
38.00	Total Non-Routine Medical Supply Charges	27,135	891	297	0	28,323	38.00

Health Financial Systems		SPARTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-3464		Period: From 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/23/2021 2:49 pm			
		RHC I		Cost			
		1.00					
1.00	Clinic Address and Identification					1.00	
	Street	1300 NORTH MARKET				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	SPARTA		IL 62286	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		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	14:00	08:00	19:00	08:00	11.00
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		6	13.00		
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	WOMENS HEALTH CLINIC		143464	14.00		
14.01		COULTERVILLE MEDICAL CLINIC		143465	14.01		
14.02		FAMILY HEALTH CLINIC		143466	14.02		
14.03		STEELEVILLE CLINIC		143467	14.03		
14.04		MARISSA MEDICAL CLINIC		143490	14.04		
14.05		SPARTA MEDICAL OFFICE		143489	14.05		
		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	RANDOLPH			2.00		

MCRIF32 - 16.12.172.5

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1349

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

Worksheet S-10

Date/Time Prepared:
11/23/2021 2:49 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.378144	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,924,251	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		1,573,171	5.00
6.00	Medicaid charges		13,777,506	6.00
7.00	Medicaid cost (line 1 times line 6)		5,209,881	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		5,141,364	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)	99,001	192,831	291,832
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	37,437	192,831	230,268
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	37,437	192,831	230,268
				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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,959,088
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			490,039
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			753,905
28.00	Non-Medicare bad debt expense (see instructions)			2,205,183
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,097,743
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,328,011
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,328,011

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		529,685		529,685	
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0		141,642	141,642
2.00	00200	CAP REL COSTS-MVBLE EQUIP		879,281		36,478	915,759
3.00	00300	OTHER CAP RELATED COST		0		0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,773,621		0	7,773,621
5.00	00500	ADMINISTRATIVE & GENERAL	3,650,340	2,871,852		-55,314	6,466,878
6.00	00600	MAINTENANCE & REPAIRS	253,805	10,459		0	264,264
7.00	00700	OPERATION OF PLANT	0	717,040		6,035	723,075
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,692		0	42,692
9.00	00900	HOUSEKEEPING	180,811	209,157		0	389,968
10.00	01000	DIETARY	174,723	100,843		54,889	330,455
11.00	01100	CAFETERIA	0	0		0	0
13.00	01300	NURSING ADMINISTRATION	149,936	315		0	150,251
15.00	01500	PHARMACY	0	1,921,777		0	1,921,777
16.00	01600	MEDICAL RECORDS & LIBRARY	155,670	26,647		0	182,317
17.00	01700	SOCIAL SERVICE	25,392	18,031		0	43,423
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		590,000	590,000
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,391,758	124,189		155,029	1,670,976
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	532,677	734,034		118,684	1,385,395
53.00	05300	ANESTHESIOLOGY	0	651,436		-598,042	53,394
54.00	05400	RADIOLOGY - DIAGNOSTIC	501,419	156,276		-110,243	547,452
54.01	05401	ULTRASOUND	143,702	87,627		877	232,206
56.00	05600	RADIOISOTOPE	0	317,743		33,690	351,433
57.00	05700	CT SCAN	0	116,775		80,502	197,277
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	116,264		29,741	146,005
60.00	06000	LABORATORY	684,046	1,392,214		-21,530	2,054,730
65.00	06500	RESPIRATORY THERAPY	54,380	25,162		-25	79,517
66.00	06600	PHYSICAL THERAPY	704,285	82,057		-1,130	785,212
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0
68.00	06800	SPEECH PATHOLOGY	0	0		0	0
69.00	06900	ELECTROCARDIOLOGY	31,396	4,041		-13,037	22,400
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		102,474	102,474
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		270,966	270,966
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0
75.01	03951	SLEEP LAB	0	141,103		0	141,103
75.02	03952	WOUND CENTER	0	104,100		26,000	130,100
76.00	03953	CARDIAC REHAB	94,385	4,258		0	98,643
76.01	03030	DIABETES EDUCATION	32,655	25,141		-54,889	2,907
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,011,571	1,943,147		-306,050	6,648,668
91.00	09100	EMERGENCY	888,432	1,378,461		-20,239	2,246,654
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,024,362	292,995		-40,122	1,277,235
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		44,015		-44,015	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,685,745	22,842,438		303,688	38,831,871
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	0
194.00	07950	FREESTANDING CLINICS	121,170	468,778		-302,652	287,296
194.01	07951	THE CENTER - FITNESS CENTER	72,491	2,627		-1,036	74,082
200.00		TOTAL (SUM OF LINES 118 through 199)	15,879,406	23,313,843		0	39,193,249

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-15,965	435,037	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	141,642	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-31,662	884,097	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,818,790	5,954,831	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-520,967	5,945,911	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	264,264	6.00
7.00	00700	OPERATION OF PLANT	0	723,075	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,692	8.00
9.00	00900	HOUSEKEEPING	0	389,968	9.00
10.00	01000	DIETARY	0	330,455	10.00
11.00	01100	CAFETERIA	-29,314	-29,314	11.00
13.00	01300	NURSING ADMINISTRATION	0	150,251	13.00
15.00	01500	PHARMACY	-756,937	1,164,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-658	181,659	16.00
17.00	01700	SOCIAL SERVICE	0	43,423	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-590,000	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-148,455	1,522,521	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-449,279	936,116	50.00
53.00	05300	ANESTHESIOLOGY	0	53,394	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	547,452	54.00
54.01	05401	ULTRASOUND	0	232,206	54.01
56.00	05600	RADIOISOTOPE	0	351,433	56.00
57.00	05700	CT SCAN	0	197,277	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	146,005	58.00
60.00	06000	LABORATORY	-650	2,054,080	60.00
65.00	06500	RESPIRATORY THERAPY	0	79,517	65.00
66.00	06600	PHYSICAL THERAPY	0	785,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,410	108,884	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	270,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03951	SLEEP LAB	0	141,103	75.01
75.02	03952	WOUND CENTER	-26,000	104,100	75.02
76.00	03953	CARDIAC REHAB	0	98,643	76.00
76.01	03030	DIABETES EDUCATION	0	2,907	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	6,648,668	88.00
91.00	09100	EMERGENCY	-539,294	1,707,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,277,235	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,921,561	33,910,310	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	287,296	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	74,082	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,921,561	34,271,688	200.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 2:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS COST OF SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	102,474		1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	270,966		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	373,440		
	B - TO RECLASS INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,050		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,965		2.00
	0		0	44,015		
	C - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	21,530	0		1.00
	0		21,530	0		
	D - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP RELATED COST	3.00	0	83,472		1.00
	0		0	83,472		
	E - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,710		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	20,710		
	F - SURGERY-FREESTANDING CLINICS					
1.00	OPERATING ROOM	50.00	0	290,961		1.00
2.00	WOUND CENTER	75.02	0	26,000		2.00
	0		0	316,961		
	G - TO RECLASS CRNA EXPENSES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	590,000		1.00
	0		0	590,000		
	H - TO RECLASS NORTH CAMPUS BLDG					
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	134,302		1.00
	0		0	134,302		
	I - TO RECLASS CT SCAN					
1.00	CT_SCAN	57.00	80,502	0		1.00
	0		80,502	0		
	J - TO RECLASS RECRUITMENT EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	46,975		1.00
	0		0	46,975		
	K - TO RECLASS STRESS TEST SALARIES					
1.00	RADIOISOTOPE	56.00	33,690	0		1.00
2.00	ULTRASOUND	54.01	877	0		2.00
	0		34,567	0		
	L - TO RECLASS MRI SALARIES					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	29,741	0		1.00
	0		29,741	0		
	M - TO RECLASS DIETARY SALARIES					
1.00	DIETARY	10.00	29,748	25,141		1.00
	0		29,748	25,141		
	O - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	6,035		1.00
2.00		0.00	0	0		2.00
	0		0	6,035		
	P - HOME HEALTH BILLER					
1.00	ADMINISTRATIVE & GENERAL	5.00	33,692	0		1.00
	0		33,692	0		
	Q - RHC - HOSPITAL SUPPORT					
1.00	ADULTS & PEDIATRICS	30.00	170,155	0		1.00
2.00	OPERATING ROOM	50.00	0	158,318		2.00
	0		170,155	158,318		
	T - COVID EXPENSES					
1.00	FREESTANDING CLINICS	194.00	21,249	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		21,249	0		
500.00	Grand Total: Increases		421,184	1,799,369		500.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 2:49 pm

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS COST OF SUPPLIES							
1.00	OPERATING ROOM	50.00	0	330,595	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,539	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	8,042	0		3.00
4.00	EMERGENCY	91.00	0	20,239	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	25	0		5.00
0			0	373,440			
B - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	44,015	11		1.00
2.00		0.00	0	0	11		2.00
0			0	44,015			
C - TO RECLASS EKG SALARIES							
1.00	LABORATORY	60.00	21,530	0	0		1.00
0			21,530	0			
D - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,472	12		1.00
0			0	83,472			
E - TO RECLASS TELEPHONE EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	587	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,130	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	10,622	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	6,430	0		4.00
5.00	FREESTANDING CLINICS	194.00	0	1,941	0		5.00
0			0	20,710			
F - SURGERY-FREESTANDING CLINICS							
1.00	FREESTANDING CLINICS	194.00	0	316,961	0		1.00
2.00		0.00	0	0	0		2.00
0			0	316,961			
G - TO RECLASS CRNA EXPENSES							
1.00	ANESTHESIOLOGY	53.00	0	590,000	0		1.00
0			0	590,000			
H - TO RECLASS NORTHCAMPUS BLDG							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	134,302	9		1.00
0			0	134,302			
I - TO RECLASS CT SCAN							
1.00	RADIOLOGY - DIAGNOSTIC	54.00	80,502	0	0		1.00
0			80,502	0			
J - TO RECLASS RECRUITMENT EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,975	0		1.00
0			0	46,975			
K - TO RECLASS STRESS TEST SALARIES							
1.00	ELECTROCARDIOLOGY	69.00	34,567	0	0		1.00
2.00		0.00	0	0	0		2.00
0			34,567	0			
L - TO RECLASS MRI SALARIES							
1.00	RADIOLOGY - DIAGNOSTIC	54.00	29,741	0	0		1.00
0			29,741	0			
M - TO RECLASS DIETARY SALARIES							
1.00	DIABETES EDUCATION	76.01	29,748	25,141	0		1.00
0			29,748	25,141			
O - UTILITY EXPENSE							
1.00	FREESTANDING CLINICS	194.00	0	4,999	0		1.00
2.00	THE CENTER - FITNESS CENTER	194.01	0	1,036	0		2.00
0			0	6,035			
P - HOME HEALTH BILLER							
1.00	HOME HEALTH AGENCY	101.00	33,692	0	0		1.00
0			33,692	0			
Q - RHC - HOSPITAL SUPPORT							
1.00	RURAL HEALTH CLINIC	88.00	170,155	158,318	0		1.00
2.00		0.00	0	0	0		2.00
0			170,155	158,318			
T - COVID EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	7,319	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	13,930	0	0		2.00
0	TOTALS		21,249	0			
500.00	Grand Total: Decreases		421,184	1,799,369			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	356,334	0	0	0	0	1.00	
2.00	Land Improvements	833,714	139,845	0	139,845	0	2.00	
3.00	Buildings and Fixtures	17,466,448	206,178	0	206,178	45,055	3.00	
4.00	Building Improvements	144,231	1,463,659	0	1,463,659	1,473,880	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	13,475,671	1,080,002	0	1,080,002	905,135	6.00	
7.00	HIT designated Assets	891,921	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	33,168,319	2,889,684	0	2,889,684	2,424,070	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	33,168,319	2,889,684	0	2,889,684	2,424,070	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	356,334	0					1.00
2.00	Land Improvements	973,559	0					
3.00	Buildings and Fixtures	17,627,571	0					
4.00	Building Improvements	134,010	0					
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	13,650,538	0					
7.00	HIT designated Assets	891,921	0					
8.00	Subtotal (sum of lines 1-7)	33,633,933	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	33,633,933	0					

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	529,685	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	879,281	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,408,966	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	529,685				1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	879,281				2.00
3.00	Total (sum of lines 1-2)	0	1,408,966				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	15,808,962	0	15,808,962	0.475064	39,654	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	2,926,178	0	2,926,178	0.087932	7,340	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,542,459	0	14,542,459	0.437004	36,478	2.00
3.00	Total (sum of lines 1-2)	33,277,599	0	33,277,599	1.000000	83,472	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	39,654	395,383	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	7,340	134,302	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	36,478	847,619	0	2.00
3.00	Total (sum of lines 1-2)	0	0	83,472	1,377,304	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	39,654	0	0	435,037	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	7,340	0	0	141,642	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	36,478	0	0	884,097	2.00
3.00	Total (sum of lines 1-2)	0	83,472	0	0	1,460,776	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-15,965	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-28,050	ADMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-30,137	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,150,378			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-29,314	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	B	6,410	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	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	-658	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-590,000	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-766	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-532	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-126,731	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT COSTS	A	-4,750	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PERSONAL USE OF AUTO	A	-4,938	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING SALARY	A	-43,588	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MARKETING EXPENSES	A	-62,043	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MARKETING EMPLOYEE BENEFITS	A	-21,338	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MARKETING CAPITAL EXPENSES	A	-504	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	LOBBYING EXPENSES	A	-8,898	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	SELF INSURANCE EXPENSE	A	-1,401,984	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MALPRACTICE INSURANCE DIVIDEND	B	-123,671	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	WORKER'S COMPENSATION INSURANCE DIVI	B	-47,469	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	RHC SELF INSURANCE EXPENSE	A	-330,953	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	USAC SUBSIDY	B	-52,708	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	340B CONTRACT EXPENSES	A	-756,937	PHARMACY	15.00	0	33.14
33.15	HOSPICE REVENUE	A	-13,300	ADULTS & PEDIATRICS	30.00	0	33.15
33.16	MRI OFFSET	A	-30,392	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	DIRECTOR OF RELATIONS NONALLOWABLE P	A	-34,821	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	DIRECTOR OF RELATIONS NONALLOWABLE B	A	-17,046	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,921,561				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1349

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

Worksheet A-8-2

Date/Time Prepared:
11/23/2021 2:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	170,155	135,155	35,000	0	0	1.00
2.00	91.00	EMERGENCY	1,227,532	539,294	688,238	0	0	2.00
3.00	50.00	OPERATING ROOM	290,961	290,961	0	0	0	3.00
4.00	75.02	WOUND CENTER	26,000	26,000	0	0	0	4.00
5.00	75.01	SLEEP LAB	13,000	0	13,000	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	20,000	0	20,000	0	0	6.00
7.00	60.00	LABORATORY	19,850	650	19,200	0	0	7.00
8.00	50.00	OPERATING ROOM	158,318	158,318	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,925,816	1,150,378	775,438		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	75.02	WOUND CENTER	0	0	0	0	0	4.00
5.00	75.01	SLEEP LAB	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	135,155		1.00
2.00	91.00	EMERGENCY	0	0	0	539,294		2.00
3.00	50.00	OPERATING ROOM	0	0	0	290,961		3.00
4.00	75.02	WOUND CENTER	0	0	0	26,000		4.00
5.00	75.01	SLEEP LAB	0	0	0	0		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0		6.00
7.00	60.00	LABORATORY	0	0	0	650		7.00
8.00	50.00	OPERATING ROOM	0	0	0	158,318		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,150,378		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 2:49 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						24	1.00
2.00	Line 1 multiplied by 15 hours per week						360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.40	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	365.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	106.58	78.95	59.21	39.47	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.48	39.48	29.61			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						28,817	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						28,817	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						28,817	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						28,817	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2021 2:49 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.95	59.21	39.47	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						28,817	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						28,817	63.00
64.00	Total cost of outside supplier services (from your records)						21,900	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	435,037	435,037			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	141,642	0	141,642		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	884,097			884,097	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,954,831	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,945,911	49,749	28,683	238,538	1,356,071
6.00	00600	MAINTENANCE & REPAIRS	264,264	20,623	0	1,149	95,650
7.00	00700	OPERATION OF PLANT	723,075	35,712	3,916	41,992	0
8.00	00800	LAUNDRY & LINEN SERVICE	42,692	3,244	0	0	0
9.00	00900	HOUSEKEEPING	389,968	4,408	0	3,351	68,141
10.00	01000	DIETARY	330,455	11,309	0	4,904	77,058
11.00	01100	CAFETERIA	-29,314	5,639	0	0	0
13.00	01300	NURSING ADMINISTRATION	150,251	1,890	0	41	56,505
15.00	01500	PHARMACY	1,164,840	2,844	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	181,659	9,234	7,133	3,504	58,666
17.00	01700	SOCIAL SERVICE	43,423	0	0	0	9,569
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,522,521	40,957	0	41,096	588,629
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	936,116	38,236	0	105,150	200,747
53.00	05300	ANESTHESIOLOGY	53,394	542	0	1,744	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	547,452	7,640	0	102,587	147,420
54.01	05401	ULTRASOUND	232,206	2,210	0	29,671	54,487
56.00	05600	RADIOISOTOPE	351,433	1,773	0	0	12,697
57.00	05700	CT SCAN	197,277	2,229	0	314	30,338
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	146,005	5,713	0	83,228	11,208
60.00	06000	LABORATORY	2,054,080	11,075	0	43,742	249,678
65.00	06500	RESPIRATORY THERAPY	79,517	1,127	0	3,357	20,494
66.00	06600	PHYSICAL THERAPY	785,212	2,961	59,163	18,908	265,420
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	22,400	1,071	0	2,395	6,919
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,884	3,515	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	270,966	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03951	SLEEP LAB	141,103	3,497	0	239	0
75.02	03952	WOUND CENTER	104,100	9,142	0	0	0
76.00	03953	CARDIAC REHAB	98,643	5,534	0	6,952	35,570
76.01	03030	DIABETES EDUCATION	2,907	0	0	0	1,096
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,648,668	86,682	42,747	72,008	1,819,310
91.00	09100	EMERGENCY	1,707,360	18,358	0	50,159	334,818
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,277,235	10,102	0	10,633	373,348
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,910,310	397,016	141,642	865,662	5,873,839
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,231	0	0	0
194.00	07950	FREESTANDING CLINICS	287,296	36,790	0	6,935	53,673
194.01	07951	THE CENTER - FITNESS CENTER	74,082	0	0	11,500	27,319
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	34,271,688	435,037	141,642	884,097	5,954,831

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,618,952	7,618,952				5.00
6.00	00600	MAINTENANCE & REPAIRS	381,686	109,012	490,698			6.00
7.00	00700	OPERATION OF PLANT	804,695	229,826	38,015	1,072,536		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,936	13,120	3,453	9,357	71,866	8.00
9.00	00900	HOUSEKEEPING	465,868	133,055	4,692	12,713	0	9.00
10.00	01000	DIETARY	423,726	121,019	12,038	32,618	0	10.00
11.00	01100	CAFETERIA	-23,675	0	6,003	16,265	0	11.00
13.00	01300	NURSING ADMINISTRATION	208,687	59,602	2,012	5,451	0	13.00
15.00	01500	PHARMACY	1,167,684	333,498	3,028	8,203	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,196	74,314	18,853	51,084	0	16.00
17.00	01700	SOCIAL SERVICE	52,992	15,135	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,193,203	626,392	43,598	118,131	17,033	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,280,249	365,647	40,701	110,283	13,155	50.00
53.00	05300	ANESTHESIOLOGY	55,680	15,903	577	1,563	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	805,099	229,941	8,132	22,035	15,310	54.00
54.01	05401	ULTRASOUND	318,574	90,987	2,353	6,374	1,628	54.01
56.00	05600	RADIOISOTOPE	365,903	104,504	1,887	5,114	0	56.00
57.00	05700	CT SCAN	230,158	65,735	2,372	6,428	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	246,154	70,303	6,081	16,478	1,335	58.00
60.00	06000	LABORATORY	2,358,575	673,623	11,789	31,943	0	60.00
65.00	06500	RESPIRATORY THERAPY	104,495	29,844	1,199	3,249	0	65.00
66.00	06600	PHYSICAL THERAPY	1,131,664	323,210	77,995	211,331	4,370	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,785	9,364	1,140	3,090	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,399	32,102	3,742	10,139	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	270,966	77,390	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	144,839	41,367	3,722	10,085	0	75.01
75.02	03952	WOUND CENTER	113,242	32,343	9,731	26,368	0	75.02
76.00	03953	CARDIAC REHAB	146,699	41,898	5,891	15,963	0	76.00
76.01	03030	DIABETES EDUCATION	4,003	1,143	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,669,415	2,476,042	110,927	146,523	0	88.00
91.00	09100	EMERGENCY	2,110,695	602,827	19,541	52,949	19,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,671,318	477,338	10,754	29,138	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,772,862	7,476,484	450,226	962,875	71,866	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,231	352	1,311	3,551	0	190.00
194.00	07950	FREESTANDING CLINICS	384,694	109,871	39,161	106,110	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	112,901	32,245	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,271,688	7,618,952	490,698	1,072,536	71,866	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	616,328					9.00
10.00	01000	DIETARY	328	589,729				10.00
11.00	01100	CAFETERIA	8,138	373,520	380,251			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	39,345	315,097		13.00
15.00	01500	PHARMACY	3,485	0	38,828	0	1,554,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,335	0	29,768	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,142	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,345	216,209	25,367	131,509	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	101,067	0	46,852	85,451	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3,106	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	12,262	0	16,825	0	0	54.00
54.01	05401	ULTRASOUND	10,127	0	2,847	0	0	54.01
56.00	05600	RADIOISOTOPE	3,613	0	1,035	0	0	56.00
57.00	05700	CT SCAN	7,591	0	6,471	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,553	0	0	58.00
60.00	06000	LABORATORY	24,560	0	44,522	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,754	0	11,648	5,716	0	65.00
66.00	06600	PHYSICAL THERAPY	27,078	0	4,400	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,554,726	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	3,576	0	0	0	0	75.01
75.02	03952	WOUND CENTER	5,255	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	24,359	0	2,847	7,670	0	76.00
76.01	03030	DIABETES EDUCATION	985	0	0	230	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	130,352	0	23,814	0	0	88.00
91.00	09100	EMERGENCY	68,205	0	53,843	84,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,609	0	5,954	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	546,024	589,729	363,167	315,097	1,554,726	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	42,934	0	16,825	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	27,370	0	259	0	0	194.01
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)	616,328	589,729	380,251	315,097	1,554,726	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	441,550					16.00
17.00	01700	SOCIAL SERVICE	0	72,269				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,400	72,269	0	3,594,456	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,033	0	0	2,089,438	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	76,829	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,893	0	0	1,113,497	0	54.00
54.01	05401	ULTRASOUND	1,374	0	0	434,264	0	54.01
56.00	05600	RADIOISOTOPE	3,435	0	0	485,491	0	56.00
57.00	05700	CT SCAN	687	0	0	319,442	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,061	0	0	343,965	0	58.00
60.00	06000	LABORATORY	30,231	0	0	3,175,243	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,657	0	0	183,562	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,780,048	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	46,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	158,382	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	348,356	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,554,726	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	7,558	0	0	211,147	0	75.01
75.02	03952	WOUND CENTER	2,519	0	0	189,458	0	75.02
76.00	03953	CARDIAC REHAB	2,519	0	0	247,846	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	6,361	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	186,422	0	0	11,743,495	0	88.00
91.00	09100	EMERGENCY	52,675	0	0	3,064,291	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,197,111	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,464	72,269	0	33,363,787	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	6,445	0	190.00
194.00	07950	FREESTANDING CLINICS	29,086	0	0	728,681	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	172,775	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	441,550	72,269	0	34,271,688	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,132	49,749	28,683	238,538	360,102 5.00
6.00	00600	MAINTENANCE & REPAIRS	566	20,623	0	1,149	22,338 6.00
7.00	00700	OPERATION OF PLANT	0	35,712	3,916	41,992	81,620 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,244	0	0	3,244 8.00
9.00	00900	HOUSEKEEPING	49	4,408	0	3,351	7,808 9.00
10.00	01000	DIETARY	0	11,309	0	4,904	16,213 10.00
11.00	01100	CAFETERIA	0	5,639	0	0	5,639 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,890	0	41	1,931 13.00
15.00	01500	PHARMACY	4,764	2,844	0	0	7,608 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,234	7,133	3,504	19,871 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,797	40,957	0	41,096	96,850 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,668	38,236	0	105,150	170,054 50.00
53.00	05300	ANESTHESIOLOGY	0	542	0	1,744	2,286 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	7,640	0	102,587	110,227 54.00
54.01	05401	ULTRASOUND	0	2,210	0	29,671	31,881 54.01
56.00	05600	RADIOISOTOPE	0	1,773	0	0	1,773 56.00
57.00	05700	CT SCAN	0	2,229	0	314	2,543 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,713	0	83,228	88,941 58.00
60.00	06000	LABORATORY	16,085	11,075	0	43,742	70,902 60.00
65.00	06500	RESPIRATORY THERAPY	12,123	1,127	0	3,357	16,607 65.00
66.00	06600	PHYSICAL THERAPY	0	2,961	59,163	18,908	81,032 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,071	0	2,395	3,466 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,515	0	0	3,515 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0	3,497	0	239	3,736 75.01
75.02	03952	WOUND CENTER	0	9,142	0	0	9,142 75.02
76.00	03953	CARDIAC REHAB	0	5,534	0	6,952	12,486 76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,791	86,682	42,747	72,008	216,228 88.00
91.00	09100	EMERGENCY	8,974	18,358	0	50,159	77,491 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	10,102	0	10,633	20,735 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,949	397,016	141,642	865,662	1,546,269 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,231	0	0	1,231 190.00
194.00	07950	FREESTANDING CLINICS	0	36,790	0	6,935	43,725 194.00
194.01	07951	THE CENTER - FITNESS CENTER	1	0	0	11,500	11,501 194.01
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	141,950	435,037	141,642	884,097	1,602,726 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	360,102				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	5,152	27,490			6.00
7.00	00700	OPERATION OF PLANT	0	10,863	2,130	94,613		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	620	193	825	4,882	8.00
9.00	00900	HOUSEKEEPING	0	6,289	263	1,121	0	9.00
10.00	01000	DIETARY	0	5,720	674	2,877	0	10.00
11.00	01100	CAFETERIA	0	0	336	1,435	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,817	113	481	0	13.00
15.00	01500	PHARMACY	0	15,763	170	724	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,512	1,056	4,506	0	16.00
17.00	01700	SOCIAL SERVICE	0	715	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	29,606	2,442	10,421	1,157	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,282	2,280	9,729	894	50.00
53.00	05300	ANESTHESIOLOGY	0	752	32	138	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	10,868	456	1,944	1,040	54.00
54.01	05401	ULTRASOUND	0	4,300	132	562	111	54.01
56.00	05600	RADIOISOTOPE	0	4,939	106	451	0	56.00
57.00	05700	CT SCAN	0	3,107	133	567	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,323	341	1,454	91	58.00
60.00	06000	LABORATORY	0	31,838	660	2,818	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,411	67	287	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,276	4,369	18,643	297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	443	64	273	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,517	210	894	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,658	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	1,955	209	890	0	75.01
75.02	03952	WOUND CENTER	0	1,529	545	2,326	0	75.02
76.00	03953	CARDIAC REHAB	0	1,980	330	1,408	0	76.00
76.01	03030	DIABETES EDUCATION	0	54	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	117,026	6,215	12,925	0	88.00
91.00	09100	EMERGENCY	0	28,492	1,095	4,671	1,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	22,561	602	2,570	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	353,368	25,223	84,940	4,882	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	17	73	313	0	190.00
194.00	07950	FREESTANDING CLINICS	0	5,193	2,194	9,360	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	1,524	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	360,102	27,490	94,613	4,882	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,481					9.00
10.00	01000	DIETARY	8	25,492				10.00
11.00	01100	CAFETERIA	204	16,146	22,060			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,283	7,625		13.00
15.00	01500	PHARMACY	88	0	2,253	0	26,606	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184	0	1,727	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	240	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,320	9,346	1,472	3,182	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,539	0	2,718	2,068	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	180	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	308	0	976	0	0	54.00
54.01	05401	ULTRASOUND	254	0	165	0	0	54.01
56.00	05600	RADIOISOTOPE	91	0	60	0	0	56.00
57.00	05700	CT SCAN	191	0	375	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	90	0	0	58.00
60.00	06000	LABORATORY	617	0	2,583	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	320	0	676	138	0	65.00
66.00	06600	PHYSICAL THERAPY	680	0	255	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	26,606	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	90	0	0	0	0	75.01
75.02	03952	WOUND CENTER	132	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	612	0	165	186	0	76.00
76.01	03030	DIABETES EDUCATION	25	0	0	6	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,274	0	1,382	0	0	88.00
91.00	09100	EMERGENCY	1,713	0	3,124	2,045	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	66	0	345	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,716	25,492	21,069	7,625	26,606	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	1,078	0	976	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	687	0	15	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	1,700	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,481	25,492	23,760	7,625	26,606	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,856					16.00
17.00	01700	SOCIAL SERVICE	0	955				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,081	955		161,832	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,217	0		210,781	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		3,388	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	272	0		126,091	0	54.00
54.01	05401	ULTRASOUND	96	0		37,501	0	54.01
56.00	05600	RADIOISOTOPE	240	0		7,660	0	56.00
57.00	05700	CT SCAN	48	0		6,964	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	144	0		94,384	0	58.00
60.00	06000	LABORATORY	2,113	0		111,531	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,024	0		20,530	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		120,552	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		4,246	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		6,136	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		3,658	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		26,606	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0	75.00
75.01	03951	SLEEP LAB	528	0		7,408	0	75.01
75.02	03952	WOUND CENTER	176	0		13,850	0	75.02
76.00	03953	CARDIAC REHAB	176	0		17,343	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		85	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,027	0		370,077	0	88.00
91.00	09100	EMERGENCY	3,681	0		123,604	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0		46,879	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,823	955	0	1,521,106	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		1,634	0	190.00
194.00	07950	FREESTANDING CLINICS	2,033	0		64,559	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		13,727	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	1,700	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,856	955	0	1,602,726	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

Period:
From 07/01/2020
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			878,516		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,800,997		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,081	5,537	237,032	3,598,304	-7,618,952
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	1,142	253,805	0
7.00	00700	OPERATION OF PLANT	5,801	756	41,727	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0
9.00	00900	HOUSEKEEPING	716	0	3,330	180,811	0
10.00	01000	DIETARY	1,837	0	4,873	204,471	0
11.00	01100	CAFETERIA	916	0	0	0	23,675
13.00	01300	NURSING ADMINISTRATION	307	0	41	149,936	0
15.00	01500	PHARMACY	462	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	3,482	155,670	0
17.00	01700	SOCIAL SERVICE	0	0	0	25,392	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,653	0	40,837	1,561,913	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,211	0	104,486	532,677	0
53.00	05300	ANESTHESIOLOGY	88	0	1,733	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	101,939	391,176	0
54.01	05401	ULTRASOUND	359	0	29,484	144,579	0
56.00	05600	RADIOISOTOPE	288	0	0	33,690	0
57.00	05700	CT SCAN	362	0	312	80,502	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	82,703	29,741	0
60.00	06000	LABORATORY	1,799	0	43,466	662,516	0
65.00	06500	RESPIRATORY THERAPY	183	0	3,336	54,380	0
66.00	06600	PHYSICAL THERAPY	481	11,421	18,789	704,285	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	174	0	2,380	18,359	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03951	SLEEP LAB	568	0	237	0	0
75.02	03952	WOUND CENTER	1,485	0	0	0	0
76.00	03953	CARDIAC REHAB	899	0	6,908	94,385	0
76.01	03030	DIABETES EDUCATION	0	0	0	2,907	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	71,553	4,827,486	0
91.00	09100	EMERGENCY	2,982	0	49,842	888,432	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,641	0	10,566	990,670	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,490	27,343	860,198	15,586,087	-7,595,277
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0
194.00	07950	FREESTANDING CLINICS	5,976	0	6,891	142,419	0
194.01	07951	THE CENTER - FITNESS CENTER	0	0	11,427	72,491	0
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)	435,037	141,642	884,097	5,954,831	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.156242	5.180192	1.006353	0.376864	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

Period:
From 07/01/2020
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,676,411				5.00
6.00	00600	MAINTENANCE & REPAIRS	381,686	74,880			6.00
7.00	00700	OPERATION OF PLANT	804,695	5,801	60,404		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,936	527	527	9,801	8.00
9.00	00900	HOUSEKEEPING	465,868	716	716	0	9.00
10.00	01000	DIETARY	423,726	1,837	1,837	0	10.00
11.00	01100	CAFETERIA	0	916	916	0	11.00
13.00	01300	NURSING ADMINISTRATION	208,687	307	307	0	13.00
15.00	01500	PHARMACY	1,167,684	462	462	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,196	2,877	2,877	0	16.00
17.00	01700	SOCIAL SERVICE	52,992	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,193,203	6,653	6,653	2,323	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,280,249	6,211	6,211	1,794	50.00
53.00	05300	ANESTHESIOLOGY	55,680	88	88	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	805,099	1,241	1,241	2,088	54.00
54.01	05401	ULTRASOUND	318,574	359	359	222	54.01
56.00	05600	RADIOISOTOPE	365,903	288	288	0	56.00
57.00	05700	CT SCAN	230,158	362	362	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	246,154	928	928	182	58.00
60.00	06000	LABORATORY	2,358,575	1,799	1,799	0	60.00
65.00	06500	RESPIRATORY THERAPY	104,495	183	183	0	65.00
66.00	06600	PHYSICAL THERAPY	1,131,664	11,902	11,902	596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,785	174	174	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,399	571	571	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	270,966	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03951	SLEEP LAB	144,839	568	568	0	75.01
75.02	03952	WOUND CENTER	113,242	1,485	1,485	0	75.02
76.00	03953	CARDIAC REHAB	146,699	899	899	0	76.00
76.01	03030	DIABETES EDUCATION	4,003	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,669,415	16,927	8,252	0	88.00
91.00	09100	EMERGENCY	2,110,695	2,982	2,982	2,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,671,318	1,641	1,641	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,177,585	68,704	54,228	9,801	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,231	200	200	0	190.00
194.00	07950	FREESTANDING CLINICS	384,694	5,976	5,976	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	112,901	0	0	0	194.01
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)	7,618,952	490,698	1,072,536	71,866	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.285606	6.553125	17.756043	7.332517	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	360,102	27,490	94,613	4,882	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013499	0.367121	1.566337	0.498112	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: 14-1349

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Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	22,879					10.00
11.00	01100	CAFETERIA	14,491	1,469				11.00
13.00	01300	NURSING ADMINISTRATION	0	152	113,552			13.00
15.00	01500	PHARMACY	0	150	0	1,921,777		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	115	0	0	1,928	16.00
17.00	01700	SOCIAL SERVICE	0	16	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,388	98	47,392	0	255	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	181	30,794	0	201	50.00
53.00	05300	ANESTHESIOLOGY	0	12	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	65	0	0	17	54.00
54.01	05401	ULTRASOUND	0	11	0	0	6	54.01
56.00	05600	RADIOISOTOPE	0	4	0	0	15	56.00
57.00	05700	CT SCAN	0	25	0	0	3	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6	0	0	9	58.00
60.00	06000	LABORATORY	0	172	0	0	132	60.00
65.00	06500	RESPIRATORY THERAPY	0	45	2,060	0	64	65.00
66.00	06600	PHYSICAL THERAPY	0	17	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,921,777	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	33	75.01
75.02	03952	WOUND CENTER	0	0	0	0	11	75.02
76.00	03953	CARDIAC REHAB	0	11	2,764	0	11	76.00
76.01	03030	DIABETES EDUCATION	0	0	83	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	92	0	0	814	88.00
91.00	09100	EMERGENCY	0	208	30,459	0	230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	23	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,879	1,403	113,552	1,921,777	1,801	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	65	0	0	127	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	1	0	0	0	194.01
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)	589,729	380,251	315,097	1,554,726	441,550	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.775995	258.850238	2.774914	0.809004	229.019710	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,492	23,760	7,625	26,606	30,856	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.114210	15.017018	0.067150	0.013844	16.004149	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: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	872	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	872	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
75.01	03951	SLEEP LAB	0	75.01
75.02	03952	WOUND CENTER	0	75.02
76.00	03953	CARDIAC REHAB	0	76.00
76.01	03030	DIABETES EDUCATION	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	872	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
194.00	07950	FREESTANDING CLINICS	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	194.01
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)	72,269	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	82.877294	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	955	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.095183	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,594,456		3,594,456	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,089,438		2,089,438	0	0	50.00
53.00	05300	ANESTHESIOLOGY	76,829		76,829	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,113,497		1,113,497	0	0	54.00
54.01	05401	ULTRASOUND	434,264		434,264	0	0	54.01
56.00	05600	RADIOISOTOPE	485,491		485,491	0	0	56.00
57.00	05700	CT SCAN	319,442		319,442	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,965		343,965	0	0	58.00
60.00	06000	LABORATORY	3,175,243		3,175,243	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	183,562	0	183,562	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,780,048	0	1,780,048	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,379		46,379	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,382		158,382	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	348,356		348,356	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,554,726		1,554,726	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03951	SLEEP LAB	211,147		211,147	0	0	75.01
75.02	03952	WOUND CENTER	189,458		189,458	0	0	75.02
76.00	03953	CARDIAC REHAB	247,846		247,846	0	0	76.00
76.01	03030	DIABETES EDUCATION	6,361		6,361	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,743,495		11,743,495	0	0	88.00
91.00	09100	EMERGENCY	3,064,291		3,064,291	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	972,175		972,175	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,197,111		2,197,111		0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,335,962	0	34,335,962	0	0	200.00
201.00		Less Observation Beds	972,175		972,175			201.00
202.00		Total (see instructions)	33,363,787	0	33,363,787	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,864,718		1,864,718		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	332,096	5,641,961	5,974,057	0.349752	0.000000
53.00	05300	ANESTHESIOLOGY	24,771	157,629	182,400	0.421212	0.000000
54.00	05400	RADIOLOGY - DIAGNOSTIC	103,902	3,621,866	3,725,768	0.298864	0.000000
54.01	05401	ULTRASOUND	111,724	4,832,039	4,943,763	0.087841	0.000000
56.00	05600	RADIOISOTOPE	7,146	1,979,611	1,986,757	0.244364	0.000000
57.00	05700	CT SCAN	207,943	14,792,341	15,000,284	0.021296	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,015	3,164,618	3,201,633	0.107434	0.000000
60.00	06000	LABORATORY	702,956	16,264,153	16,967,109	0.187141	0.000000
65.00	06500	RESPIRATORY THERAPY	2,164	418,432	420,596	0.436433	0.000000
66.00	06600	PHYSICAL THERAPY	613,736	5,421,824	6,035,560	0.294927	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	19,055	616,356	635,411	0.072991	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,297	913,492	1,008,789	0.157002	0.000000
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	76,107	449,707	525,814	0.662508	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	400,138	2,453,303	2,853,441	0.544860	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
75.01	03951	SLEEP LAB	923	1,000,225	1,001,148	0.210905	0.000000
75.02	03952	WOUND CENTER	0	560,609	560,609	0.337950	0.000000
76.00	03953	CARDIAC REHAB	0	260,662	260,662	0.950833	0.000000
76.01	03030	DIABETES EDUCATION	0	561	561	11.338681	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,935,384	9,935,384		88.00
91.00	09100	EMERGENCY	71,794	6,542,637	6,614,431	0.463274	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,820	415,860	424,680	2.289194	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	4,106,895	4,106,895		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,680,305	83,550,165	88,230,470		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,680,305	83,550,165	88,230,470		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03951	SLEEP LAB	0.000000			75.01
75.02	03952	WOUND CENTER	0.000000			75.02
76.00	03953	CARDIAC REHAB	0.000000			76.00
76.01	03030	DIABETES EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	210,781	5,974,057	0.035283	174,149	6,144	50.00
53.00	05300 ANESTHESIOLOGY	3,388	182,400	0.018575	10,834	201	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	126,091	3,725,768	0.033843	57,894	1,959	54.00
54.01	05401 ULTRASOUND	37,501	4,943,763	0.007586	65,528	497	54.01
56.00	05600 RADIOISOTOPE	7,660	1,986,757	0.003856	0	0	56.00
57.00	05700 CT SCAN	6,964	15,000,284	0.000464	123,853	57	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	94,384	3,201,633	0.029480	18,510	546	58.00
60.00	06000 LABORATORY	111,531	16,967,109	0.006573	323,318	2,125	60.00
65.00	06500 RESPIRATORY THERAPY	20,530	420,596	0.048812	144	7	65.00
66.00	06600 PHYSICAL THERAPY	120,552	6,035,560	0.019974	84,997	1,698	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	4,246	635,411	0.006682	10,322	69	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,136	1,008,789	0.006083	46,193	281	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,658	525,814	0.006957	43,489	303	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,606	2,853,441	0.009324	183,305	1,709	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	7,408	1,001,148	0.007400	0	0	75.01
75.02	03952 WOUND CENTER	13,850	560,609	0.024705	0	0	75.02
76.00	03953 CARDIAC REHAB	17,343	260,662	0.066534	0	0	76.00
76.01	03030 DIABETES EDUCATION	85	561	0.151515	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	370,077	9,935,384	0.037248	0	0	88.00
91.00	09100 EMERGENCY	123,604	6,614,431	0.018687	12,153	227	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	43,770	424,680	0.103066	2,020	208	92.00
200.00	Total (lines 50 through 199)	1,356,165	82,258,857		1,156,709	16,031	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0	0	0	0	0 75.01
75.02	03952	WOUND CENTER	0	0	0	0	0 75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,974,057	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	182,400	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	3,725,768	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,943,763	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,986,757	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	15,000,284	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,201,633	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	16,967,109	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	420,596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,035,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	635,411	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,008,789	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	525,814	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,853,441	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03951	SLEEP LAB	0	0	0	1,001,148	0.000000	75.01
75.02	03952	WOUND CENTER	0	0	0	560,609	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	0	0	260,662	0.000000	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	561	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	9,935,384	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,614,431	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	424,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	82,258,857		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	174,149	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,834	0	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	57,894	0	0	0 54.00
54.01	05401	ULTRASOUND	0.000000	65,528	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	123,853	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	18,510	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	323,318	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	144	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	84,997	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,322	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	46,193	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	43,489	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	183,305	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0.000000	0	0	0	0 75.01
75.02	03952	WOUND CENTER	0.000000	0	0	0	0 75.02
76.00	03953	CARDIAC REHAB	0.000000	0	0	0	0 76.00
76.01	03030	DIABETES EDUCATION	0.000000	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	12,153	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,020	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,156,709	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 2:49 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.349752	0	1,855,196	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.421212	0	39,656	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.298864	0	857,778	0	0	54.00
54.01	05401	ULTRASOUND	0.087841	0	1,863,612	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244364	0	897,297	0	0	56.00
57.00	05700	CT SCAN	0.021296	0	5,727,169	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.107434	0	1,083,215	0	0	58.00
60.00	06000	LABORATORY	0.187141	0	5,457,080	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.436433	0	177,001	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.294927	0	1,688,340	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072991	0	243,665	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157002	0	262,787	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.662508	0	157,480	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.544860	0	1,063,110	46,788	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.210905	0	388,155	0	0	75.01
75.02	03952	WOUND CENTER	0.337950	0	409,914	0	0	75.02
76.00	03953	CARDIAC REHAB	0.950833	0	132,540	0	0	76.00
76.01	03030	DIABETES EDUCATION	11.338681	0	187	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.463274	0	2,181,989	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.289194	0	175,700	0	0	92.00
200.00		Subtotal (see instructions)		0	24,661,871	46,788	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	24,661,871	46,788	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 2:49 pm

			Title XVIII		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	648,859	0		50.00
53.00	05300	ANESTHESIOLOGY	16,704	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	256,359	0		54.00
54.01	05401	ULTRASOUND	163,702	0		54.01
56.00	05600	RADIOISOTOPE	219,267	0		56.00
57.00	05700	CT SCAN	121,966	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	116,374	0		58.00
60.00	06000	LABORATORY	1,021,243	0		60.00
65.00	06500	RESPIRATORY THERAPY	77,249	0		65.00
66.00	06600	PHYSICAL THERAPY	497,937	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	17,785	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,258	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	104,332	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,246	25,493		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03951	SLEEP LAB	81,864	0		75.01
75.02	03952	WOUND CENTER	138,530	0		75.02
76.00	03953	CARDIAC REHAB	126,023	0		76.00
76.01	03030	DIABETES EDUCATION	2,120	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,010,859	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	402,211	0		92.00
200.00		Subtotal (see instructions)	5,643,888	25,493		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,643,888	25,493		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 2:49 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,290	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,482	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)			872	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			385	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)			384	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			19	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			527	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)			360	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)			238	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,594,456	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			3,393	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			3,572	25.00
26.00	Total swing-bed cost (see instructions)			1,232,543	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,361,913	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)			2,361,913	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,593.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			839,896	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)			839,896	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					325,741	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,165,637	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)					573,743	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					379,308	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					953,051	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)					610	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,593.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					972,175	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 2:49 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	161,832	3,594,456	0.045023	972,175	43,770
91.00	Nursing School cost	0	3,594,456	0.000000	972,175	0
92.00	Allied health cost	0	3,594,456	0.000000	972,175	0
93.00	All other Medical Education	0	3,594,456	0.000000	972,175	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 2:49 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		380,214		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.349752	174,149	60,909	50.00
53.00	05300 ANESTHESIOLOGY	0.421212	10,834	4,563	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.298864	57,894	17,302	54.00
54.01	05401 ULTRASOUND	0.087841	65,528	5,756	54.01
56.00	05600 RADIOISOTOPE	0.244364	0	0	56.00
57.00	05700 CT SCAN	0.021296	123,853	2,638	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.107434	18,510	1,989	58.00
60.00	06000 LABORATORY	0.187141	323,318	60,506	60.00
65.00	06500 RESPIRATORY THERAPY	0.436433	144	63	65.00
66.00	06600 PHYSICAL THERAPY	0.294927	84,997	25,068	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.072991	10,322	753	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157002	46,193	7,252	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.662508	43,489	28,812	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.544860	183,305	99,876	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.210905	0	0	75.01
75.02	03952 WOUND CENTER	0.337950	0	0	75.02
76.00	03953 CARDIAC REHAB	0.950833	0	0	76.00
76.01	03030 DIABETES EDUCATION	11.338681	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.463274	12,153	5,630	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.289194	2,020	4,624	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,156,709	325,741	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,156,709		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349 Component CCN: 14-Z349	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 2:49 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.349752	4,016	1,405	50.00
53.00	05300 ANESTHESIOLOGY	0.421212	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.298864	14,089	4,211	54.00
54.01	05401 ULTRASOUND	0.087841	1,400	123	54.01
56.00	05600 RADIOISOTOPE	0.244364	0	0	56.00
57.00	05700 CT SCAN	0.021296	11,555	246	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.107434	3,399	365	58.00
60.00	06000 LABORATORY	0.187141	137,154	25,667	60.00
65.00	06500 RESPIRATORY THERAPY	0.436433	351	153	65.00
66.00	06600 PHYSICAL THERAPY	0.294927	365,526	107,803	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.072991	2,184	159	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157002	7,346	1,153	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.662508	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.544860	78,959	43,022	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.210905	0	0	75.01
75.02	03952 WOUND CENTER	0.337950	0	0	75.02
76.00	03953 CARDIAC REHAB	0.950833	0	0	76.00
76.01	03030 DIABETES EDUCATION	11.338681	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.463274	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.289194	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		625,979	184,307	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		625,979		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 2:49 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,669,381	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,669,381	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,726,075	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		36,714	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,817,381	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,871,980	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,871,980	30.00
31.00	Primary payer payments		1,945	31.00
32.00	Subtotal (line 30 minus line 31)		1,870,035	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		607,904	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		395,138	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		310,355	36.00
37.00	Subtotal (see instructions)		2,265,173	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,265,173	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,352,065	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-86,892	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 2:49 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		952,430		2,691,602	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/05/2021	58,338	02/05/2021	339,537	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)		-58,338		-339,537	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)		894,092		2,352,065	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		142,279		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		86,892	6.02
7.00	Total Medicare program liability (see instructions)		1,036,371		2,265,173	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: 14-1349

Period:

Worksheet E-1

Component CCN: 14-Z349

From 07/01/2020

Part I

To 06/30/2021

Date/Time Prepared:

11/23/2021 2:49 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,143,284		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/05/2021	104,315		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)		-104,315		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,038,969		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		104,470		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,143,439		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: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/23/2021 2:49 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-Z349		Date/Time Prepared: 11/23/2021 2:49 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		962,582	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)		186,150	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		598	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,148,732	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,148,732	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,148,732	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,404	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,143,328	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)		171	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		111	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,143,439	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,038,969	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)		104,470	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:14-1349	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/23/2021 2:49 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,165,637	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,165,637	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,177,293	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,177,293	19.00
20.00	Deductibles (exclude professional component)		166,275	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,011,018	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,011,018	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		39,004	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		25,353	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,818	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,036,371	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,036,371	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		894,092	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)		142,279	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1349

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

Worksheet G

Date/Time Prepared:
11/23/2021 2:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	30,741,895	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,705,424	0	0	0	4.00
5.00	Other receivable	227,147	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,549,553	0	0	0	6.00
7.00	Inventory	564,133	0	0	0	7.00
8.00	Prepaid expenses	1,092,880	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	36,781,926	0	0	0	11.00
FIXED ASSETS						
12.00	Land	356,334	0	0	0	12.00
13.00	Land improvements	973,560	0	0	0	13.00
14.00	Accumulated depreciation	-717,140	0	0	0	14.00
15.00	Buildings	17,693,444	0	0	0	15.00
16.00	Accumulated depreciation	-14,175,834	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	23,015	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	14,519,444	0	0	0	23.00
24.00	Accumulated depreciation	-11,341,096	0	0	0	24.00
25.00	Minor equipment depreciable	7,162	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	60,974	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,399,863	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,407,315	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,407,315	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,589,104	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	701,707	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,439,244	0	0	0	38.00
39.00	Payroll taxes payable	6,426,082	0	0	0	39.00
40.00	Notes and loans payable (short term)	478,284	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	-624,480	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)	8,420,837	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	403,322	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)	403,322	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,824,159	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	37,764,945				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)	37,764,945	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,589,104	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1349

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

Worksheet G-1

Date/Time Prepared:
11/23/2021 2:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,465,390		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,299,555				2.00
3.00	Total (sum of line 1 and line 2)		37,764,945		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)		37,764,945		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)		37,764,945		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: 14-1349

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 2:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,734,828		1,734,828	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	138,420		138,420	5.00
6.00	Swing bed - NF	7,020		7,020	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,880,268		1,880,268	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,880,268		1,880,268	17.00
18.00	Ancillary services	2,796,370	64,095,114	66,891,484	18.00
19.00	Outpatient services	80,614	7,020,364	7,100,978	19.00
20.00	RURAL HEALTH CLINIC	0	10,425,449	10,425,449	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,106,895	4,106,895	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	60,807	1,636,802	1,697,609	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,818,059	87,284,624	92,102,683	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,193,249		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)		39,193,249		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1349

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

Worksheet G-3

Date/Time Prepared:
11/23/2021 2:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,102,683	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,089,019	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,013,664	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,193,249	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,179,585	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	223,571	6.00
7.00	Income from investments	53,320	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	29,314	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	658	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	169,470	22.00
23.00	Governmental appropriations	286,957	23.00
24.00	OTHER MISC REVENUE	3,212,306	24.00
24.01	340B CONTRACT PHARMACY REVENUE	1,818,679	24.01
24.50	COVID-19 PHE Funding	4,684,865	24.50
25.00	Total other income (sum of lines 6-24)	10,479,140	25.00
26.00	Total (line 5 plus line 25)	9,299,555	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)	9,299,555	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS				Provider CCN: 14-1349 HHA CCN: 14-7694		Period: From 07/01/2020 To 06/30/2021		Worksheet H Date/Time Prepared: 11/23/2021 2:49 pm	
						Home Health Agency I		PPS	
		Salaries	Employee Benefits	Transportatio n (see instructions)	Contracted/Pu rchased Services	Other Costs	Total (sum of cols. 1 thru 5)		
		1.00	2.00	3.00	4.00	5.00	6.00		
GENERAL SERVICE COST CENTERS									
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00	
2.00	Capital Related - Movable Equipment			0		0	0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		12,708	12,708	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	311,825	0	0	0	271,467	583,292	5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	457,510	0	0	0	0	457,510	6.00	
7.00	Physical Therapy	214,436	0	0	0	0	214,436	7.00	
8.00	Occupational Therapy	40,591	0	0	0	0	40,591	8.00	
9.00	Speech Pathology	0	0	0	8,820	0	8,820	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	0	0	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES									
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	1,024,362	0	0	8,820	284,175	1,317,357	24.00	
		Reclassificat ion	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)				
		7.00	8.00	9.00	10.00				
GENERAL SERVICE COST CENTERS									
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00	
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00	
3.00	Plant Operation & Maintenance	0	12,708	0	12,708			3.00	
4.00	Transportation	0	0	0	0			4.00	
5.00	Administrative and General	-40,122	543,170	0	543,170			5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	0	457,510	0	457,510			6.00	
7.00	Physical Therapy	0	214,436	0	214,436			7.00	
8.00	Occupational Therapy	0	40,591	0	40,591			8.00	
9.00	Speech Pathology	0	8,820	0	8,820			9.00	
10.00	Medical Social Services	0	0	0	0			10.00	
11.00	Home Health Aide	0	0	0	0			11.00	
12.00	Supplies (see instructions)	0	0	0	0			12.00	
13.00	Drugs	0	0	0	0			13.00	
14.00	DME	0	0	0	0			14.00	
HHA NONREIMBURSABLE SERVICES									
15.00	Home Dialysis Aide Services	0	0	0	0			15.00	
16.00	Respiratory Therapy	0	0	0	0			16.00	
17.00	Private Duty Nursing	0	0	0	0			17.00	
18.00	Clinic	0	0	0	0			18.00	
19.00	Health Promotion Activities	0	0	0	0			19.00	
20.00	Day Care Program	0	0	0	0			20.00	
21.00	Home Delivered Meals Program	0	0	0	0			21.00	
22.00	Homemaker Service	0	0	0	0			22.00	
23.00	All Others (specify)	0	0	0	0			23.00	
23.50	Telemedicine	0	0	0	0			23.50	
24.00	Total (sum of lines 1-23)	-40,122	1,277,235	0	1,277,235			24.00	

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	12,708	0	0	12,708		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	543,170	0	0	12,708	0	555,878	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	457,510	0	0	0	0	457,510	6.00
7.00	Physical Therapy	214,436	0	0	0	0	214,436	7.00
8.00	Occupational Therapy	40,591	0	0	0	0	40,591	8.00
9.00	Speech Pathology	8,820	0	0	0	0	8,820	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,277,235	0	0	12,708	0	1,277,235	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	555,878						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	352,558	810,068					6.00
7.00	Physical Therapy	165,244	379,680					7.00
8.00	Occupational Therapy	31,279	71,870					8.00
9.00	Speech Pathology	6,797	15,617					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,277,235					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00	3.00	4.00	5A.00	5.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	1,641		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	1,641	0	-555,878	721,357	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	457,510	6.00	
7.00	Physical Therapy	0	0	0	0	0	214,436	7.00	
8.00	Occupational Therapy	0	0	0	0	0	40,591	8.00	
9.00	Speech Pathology	0	0	0	0	0	8,820	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	0	0	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-555,878	721,357	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	12,708	0		555,878	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	7.744059	0.000000		0.770600	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	10,102	0	10,633	104,818	125,553	1.00
2.00	Skilled Nursing Care	810,068	0	0	0	172,420	982,488	2.00
3.00	Physical Therapy	379,680	0	0	0	80,813	460,493	3.00
4.00	Occupational Therapy	71,870	0	0	0	15,297	87,167	4.00
5.00	Speech Pathology	15,617	0	0	0	0	15,617	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,277,235	10,102	0	10,633	373,348	1,671,318	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	35,859	10,754	29,138	0	2,609	0	1.00
2.00	Skilled Nursing Care	280,604	0	0	0	0	0	2.00
3.00	Physical Therapy	131,520	0	0	0	0	0	3.00
4.00	Occupational Therapy	24,895	0	0	0	0	0	4.00
5.00	Speech Pathology	4,460	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	477,338	10,754	29,138	0	2,609	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	5,954	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	5,954	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	209,867	0	209,867				1.00
2.00	Skilled Nursing Care	1,263,092	0	1,263,092	133,391	1,396,483		2.00
3.00	Physical Therapy	592,013	0	592,013	62,521	654,534		3.00
4.00	Occupational Therapy	112,062	0	112,062	11,835	123,897		4.00
5.00	Speech Pathology	20,077	0	20,077	2,120	22,197		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	2,197,111	0	2,197,111	209,867	2,197,111		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.105607			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00				
1.00	Administrative and General	1,641	0	10,566	278,133	0	125,553	1.00
2.00	Skilled Nursing Care	0	0	0	457,510	0	982,488	2.00
3.00	Physical Therapy	0	0	0	214,436	0	460,493	3.00
4.00	Occupational Therapy	0	0	0	40,591	0	87,167	4.00
5.00	Speech Pathology	0	0	0	0	0	15,617	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	0	10,566	990,670		1,671,318	20.00
21.00	Total cost to be allocated	10,102	0	10,633	373,348		477,338	21.00
22.00	Unit cost multiplier	6.156002	0.000000	1.006341	0.376864		0.285606	22.00
Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	1,641	0	715	0	23	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	1,641	0	715	0	23	20.00
21.00	Total cost to be allocated	10,754	29,138	0	2,609	0	5,954	21.00
22.00	Unit cost multiplier	6.553321	17.756246	0.000000	3.648951	0.000000	258.869565	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

HHA CCN: 14-7694

Period:
From 07/01/2020
To 06/30/2021Worksheet H-2
Part II
Date/Time Prepared:
11/23/2021 2:49 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	15.00	16.00	17.00	19.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Title XVIII				Home Health Agency I		PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,396,483		1,396,483	7,669	182.09
2.00	Physical Therapy	3.00	654,534	0	654,534	5,360	122.11
3.00	Occupational Therapy	4.00	123,897	0	123,897	653	189.74
4.00	Speech Pathology	5.00	22,197	0	22,197	105	211.40
5.00	Medical Social Services	6.00	0	0	0	0	0.00
6.00	Home Health Aide	7.00	0	0	0	0	0.00
7.00	Total (sum of lines 1-6)		2,197,111	0	2,197,111	13,787	
Program Visits							
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		16060	0	85		8.00
8.01	Skilled Nursing Care		41180	0	608		8.01
8.02	Skilled Nursing Care		99913	0	8		8.02
8.03	Skilled Nursing Care		99914	0	2,567		8.03
9.00	Physical Therapy		16060	0	106		9.00
9.01	Physical Therapy		41180	0	428		9.01
9.02	Physical Therapy		99913	0	6		9.02
9.03	Physical Therapy		99914	0	2,117		9.03
10.00	Occupational Therapy		16060	0	6		10.00
10.01	Occupational Therapy		41180	0	30		10.01
10.02	Occupational Therapy		99913	0	0		10.02
10.03	Occupational Therapy		99914	0	207		10.03
11.00	Speech Pathology		16060	0	0		11.00
11.01	Speech Pathology		41180	0	3		11.01
11.02	Speech Pathology		99913	0	0		11.02
11.03	Speech Pathology		99914	0	33		11.03
12.00	Medical Social Services		16060	0	0		12.00
12.01	Medical Social Services		41180	0	0		12.01
12.02	Medical Social Services		99913	0	0		12.02
12.03	Medical Social Services		99914	0	0		12.03
13.00	Home Health Aide		16060	0	0		13.00
13.01	Home Health Aide		41180	0	0		13.01
13.02	Home Health Aide		99913	0	0		13.02
13.03	Home Health Aide		99914	0	0		13.03
14.00	Total (sum of lines 8-13)			0	6,204		14.00
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Visits			Cost of Services	Agency 1		
		Part A	Part B			Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
								6.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	3,268		0	595,070		1.00
2.00	Physical Therapy	0	2,657		0	324,446		2.00
3.00	Occupational Therapy	0	243		0	46,107		3.00
4.00	Speech Pathology	0	36		0	7,610		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	6,204		0	973,233		7.00
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B			Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	28,324	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 2:49 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Total Program Cost (sum of cols. 9-10)		
		12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION				
Cost Per Visit Computation				
1.00	Skilled Nursing Care	595,070		1.00
2.00	Physical Therapy	324,446		2.00
3.00	Occupational Therapy	46,107		3.00
4.00	Speech Pathology	7,610		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	0		6.00
7.00	Total (sum of lines 1-6)	973,233		7.00
Cost Center Description		12.00		
Limitation Cost Computation				
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
11/23/2021 2:49 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.294927	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.157002	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.544860	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2020 To 06/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 11/23/2021 2:49 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0 1.00
2.00	Total charges	0	0	0 2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0 3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)	0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0 8.00
9.00	Primary payer amounts	0	4,069	0 9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-4,069 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	995,034 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	70,388 12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	9,447 13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	0 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	14,460 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0 16.00
17.00	Total Other Payments		0	0 17.00
18.00	DME Payments		0	0 18.00
19.00	Oxygen Payments		0	0 19.00
20.00	Prosthetic and Orthotic Payments		0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,085,260 22.00
23.00	Excess reasonable cost (from line 8)		0	0 23.00
24.00	Subtotal (line 22 minus line 23)		0	1,085,260 24.00
25.00	Coinsurance billed to program patients (from your records)		0	0 25.00
26.00	Net cost (line 24 minus line 25)		0	1,085,260 26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,085,260 29.00
30.00	PS&R OTHER ADJUSTMENTS		0	-2,304 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0 30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0 30.99
31.00	Subtotal (see instructions)		0	1,082,956 31.00
31.01	Sequestration adjustment (see instructions)		0	0 31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0 31.02
32.00	Interim payments (see instructions)		0	1,082,956 32.00
33.00	Tentative settlement (for contractor use only)		0	0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1349
HHA CCN: 14-7694Period:
From 07/01/2020
To 06/30/2021Worksheet H-5
Date/Time Prepared:
11/23/2021 2:49 pm

		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		1,082,956
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,082,956
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		1,082,956
		Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00 2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 2:49 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	2,398,602	929,655	3,328,257	-356,444	2,971,813	1.00
2.00	Physician Assistant	193,556	0	193,556	12,382	205,938	2.00
3.00	Nurse Practitioner	645,766	0	645,766	-2,530	643,236	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,314,517	0	1,314,517	-13,930	1,300,587	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	968	968	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,552,441	929,655	5,482,096	-359,554	5,122,542	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	505,459	505,459	0	505,459	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	172,488	172,488	0	172,488	18.00
19.00	Other Health Care Costs	0	32,982	32,982	0	32,982	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	710,929	710,929	0	710,929	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,552,441	1,640,584	6,193,025	-359,554	5,833,471	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	17,150	17,150	25.01
25.02	Chronic Care Management	0	82,920	82,920	0	82,920	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	82,920	82,920	17,150	100,070	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	64,918	64,918	0	64,918	29.00
30.00	Administrative Costs	459,131	154,725	613,856	36,353	650,209	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	459,131	219,643	678,774	36,353	715,127	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,011,572	1,943,147	6,954,719	-306,051	6,648,668	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2020
To 06/30/2021Date/Time Prepared:
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		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	2,971,813	1.00
2.00	Physician Assistant	0	205,938	2.00
3.00	Nurse Practitioner	0	643,236	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,300,587	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	968	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	5,122,542	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	505,459	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	172,488	18.00
19.00	Other Health Care Costs	0	32,982	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	710,929	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	5,833,471	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	17,150	25.01
25.02	Chronic Care Management	0	82,920	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	100,070	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	64,918	29.00
30.00	Administrative Costs	0	650,209	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	715,127	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	6,648,668	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1349

Period:

Worksheet M-2

Component CCN: 14-3464

From 07/01/2020
To 06/30/2021Date/Time Prepared:
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				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	7.75	24,197	3,150	24,413		1.00
2.00	Physician Assistant	1.31	3,964	2,100	2,751		2.00
3.00	Nurse Practitioner	5.60	14,595	2,100	11,760		3.00
4.00	Subtotal (sum of lines 1 through 3)	14.66	42,756		38,924	42,756	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.01	16			16	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	14.67	42,772			42,772	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					5,833,471	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					100,070	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,933,541	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.983135	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					715,127	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					5,094,827	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,809,954	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,809,954	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,711,969	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					11,545,440	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 2:49 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			11,545,440	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			357,344	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			11,188,096	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			42,772	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)			42,772	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			261.58	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	246.18	8.00
9.00	Rate for Program covered visits (see instructions)	261.58	261.58	246.18	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	5,485	2,618	2,778	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,434,766	684,816	683,888	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	2,803,470		16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,143,612		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		92,264		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		120,664		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.)		2,016,498		16.04
16.05	Total program cost (see instructions)	0	2,137,162		16.05
17.00	Primary payer amounts		186		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		162,183		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		377,833		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,136,976		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		116,163		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,253,139		22.00
23.00	Allowable bad debts (see instructions)		106,826		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		69,437		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		76,544		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)		2,322,576		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		1,842,033		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)		480,543		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1349

Period:

Worksheet M-4

Component CCN: 14-3464

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 2:49 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	5,122,542	5,122,542	5,122,542	5,122,542	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000473	0.002429	0.000057	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,423	12,443	292	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	83,435	81,959	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	85,858	94,402	292	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,833,471	5,833,471	5,833,471	5,833,471	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,711,969	5,711,969	5,711,969	5,711,969	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014718	0.016183	0.000050	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	84,069	92,437	286	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	169,927	186,839	578	0	10.00
11.00	Total number of injections/infusions (from your records)	509	2,611	61	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	333.84	71.56	9.48	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	193	722	6	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			1	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	64,431	51,666	66	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		357,344			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		116,163			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 2:49 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,964,989	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		06/17/2021	33,028	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		02/05/2021	155,984	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)		-122,956	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,842,033	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		480,543	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,322,576	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00