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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 11:27 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/27/2022 Time: 11:27 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	130,873	-411,606	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	127,181	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		87,701		0	10.00
10.01	RURAL HEALTH CLINIC II	0		96,469		0	10.01
10.02	RURAL HEALTH CLINIC III	0		18,267		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		31,039		0	10.03
200.00	Total	0	258,054	-178,130	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: R.R 1	PO Box: 1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MY LINTON CLINIC	158535	99915		12/18/2018	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MY BLOOMFIELD CLINIC	158533	99915		12/18/2018	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MY WESTGATE CLINIC	158534	99915		12/18/2018	N	N	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	MY WORTHINGTON CLINIC	158538	99915		12/12/2018	N	N	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

		1.00	2.00	3.00	
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.	0			23.00

		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.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
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

		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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 11:27 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	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:	369,560	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2022 11:27 am

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 11:27 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 11:27 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/31/2022	Y	03/31/2022	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2022 11:27 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO		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.	3173834000		KBEJARANO@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 11:27 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 11:27 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	47,952.00	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)		20	7,300	47,952.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	6,312.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	54,264.00	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 11:27 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,030	33	1,987			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	306	0	385			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,336	33	2,372			7.00
8.00	INTENSIVE CARE UNIT	156	5	263			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		6	120			13.00
14.00	Total (see instructions)	1,492	44	2,755	0.00	313.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,444	571	21,128	0.00	19.25	26.00
26.01	RURAL HEALTH CLINIC II	1,228	92	5,841	0.00	24.01	26.01
26.02	RURAL HEALTH CLINIC III	334	20	2,031	0.00	8.00	26.02
26.03	RURAL HEALTH CLINIC IV	558	77	2,655	0.00	3.38	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	368.20	27.00
28.00	Observation Bed Days		93	1,035			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	35	50			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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2022 11:27 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	308	54	786	1.00
2.00	HMO and other (see instructions)			33	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	308	54	786	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			1210 N. 1000 W.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LINTON		IN	47441	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	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		GREENE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC I

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC II

				1.00		
	Clinic Address and Identification					
1.00	Street			55 N. JUDGE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BLOOMFIELD		IN	47424	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC					11.00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	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		GREENE			2.00
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC II

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC III

				1.00		
	Clinic Address and Identification					
1.00	Street			1985 E. FREEDOM DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEWBERRY		IN	47449	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	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		GREENE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317
Component CCN: 15-8534

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

Worksheet S-8

Date/Time Prepared:
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RHC III

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/27/2022 11:27 am

RHC IV

				1.00		
	Clinic Address and Identification					
1.00	Street			102 E. MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WORTHINGTON		IN	47471	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	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		GREENE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1317
Component CCN: 15-8538

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

Worksheet S-8

Date/Time Prepared:
5/27/2022 11:27 am

RHC IV

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/27/2022 11:27 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.329154	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,047,678	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	599,048	5.00
6.00	Medicaid charges	34,179,405	6.00
7.00	Medicaid cost (line 1 times line 6)	11,250,288	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)	7,603,562	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,603,562	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)	221,979	0	221,979	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	73,065	0	73,065	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	73,065	0	73,065	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,725,052	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	707,478	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,088,428	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,636,624	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,236,267	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,309,332	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,912,894	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 11:27 am

		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		1,225,913	1,225,913	66,539	1,292,452	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		634,533	634,533	0	634,533	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,508,445	4,508,445	83,669	4,592,114	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,518,258	6,752,642	9,270,900	444,602	9,715,502	5.00
7.00	00700	OPERATION OF PLANT	692,226	1,041,009	1,733,235	0	1,733,235	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	266	266	205,187	205,453	8.00
9.00	00900	HOUSEKEEPING	318,364	338,310	656,674	-205,187	451,487	9.00
10.00	01000	DIETARY	630,111	389,629	1,019,740	-829,456	190,284	10.00
11.00	01100	CAFETERIA	0	0	0	829,456	829,456	11.00
13.00	01300	NURSING ADMINISTRATION	1,043,241	193,422	1,236,663	-308,119	928,544	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,673	45,673	0	45,673	14.00
15.00	01500	PHARMACY	626,872	100,751	727,623	0	727,623	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,376	35,083	299,459	0	299,459	16.00
17.00	01700	SOCIAL SERVICE	250,953	20,268	271,221	0	271,221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	509,479	509,479	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,512,135	302,599	2,814,734	671,883	3,486,617	30.00
31.00	03100	INTENSIVE CARE UNIT	569,813	49,864	619,677	0	619,677	31.00
43.00	04300	NURSERY	0	4,840	4,840	48,780	53,620	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	550,663	162,474	713,137	-2,250	710,887	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,229	803	238,032	-236,388	1,644	52.00
53.00	05300	ANESTHESIOLOGY	0	658,519	658,519	-507,229	151,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,030,478	768,862	1,799,340	0	1,799,340	54.00
60.00	06000	LABORATORY	885,689	2,188,109	3,073,798	0	3,073,798	60.00
65.00	06500	RESPIRATORY THERAPY	730,710	89,709	820,419	-5,062	815,357	65.00
66.00	06600	PHYSICAL THERAPY	545,958	79,299	625,257	0	625,257	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,357	69	178,426	0	178,426	67.00
68.00	06800	SPEECH PATHOLOGY	43,720	0	43,720	0	43,720	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,356,830	1,356,830	-538,836	817,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	538,836	538,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	263,639	2,096,846	2,360,485	0	2,360,485	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,543,783	1,374,834	3,918,617	-194,101	3,724,516	88.00
88.01	08801	RURAL HEALTH CLINIC II	625,516	352,749	978,265	72,851	1,051,116	88.01
88.02	08802	RURAL HEALTH CLINIC III	251,498	170,411	421,909	-17,016	404,893	88.02
88.03	08803	RURAL HEALTH CLINIC IV	244,458	129,387	373,845	-113,227	260,618	88.03
91.00	09100	EMERGENCY	2,923,913	914,470	3,838,383	5,062	3,843,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,481,960	25,986,618	46,468,578	519,473	46,988,051	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,489,643	434,379	2,924,022	-519,473	2,404,549	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	22,971,603	26,420,997	49,392,600	0	49,392,600	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-56,919	1,235,533		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	634,533		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,592,114		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,866,368	6,849,134		5.00
7.00	00700	OPERATION OF PLANT	-3,637	1,729,598		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	205,453		8.00
9.00	00900	HOUSEKEEPING	0	451,487		9.00
10.00	01000	DIETARY	0	190,284		10.00
11.00	01100	CAFETERIA	-236,051	593,405		11.00
13.00	01300	NURSING ADMINISTRATION	0	928,544		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,673		14.00
15.00	01500	PHARMACY	0	727,623		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,622	294,837		16.00
17.00	01700	SOCIAL SERVICE	0	271,221		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-258,197	251,282		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-539,740	2,946,877		30.00
31.00	03100	INTENSIVE CARE UNIT	0	619,677		31.00
43.00	04300	NURSERY	0	53,620		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	710,887		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,644		52.00
53.00	05300	ANESTHESIOLOGY	0	151,290		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,799,340		54.00
60.00	06000	LABORATORY	0	3,073,798		60.00
65.00	06500	RESPIRATORY THERAPY	-11,040	804,317		65.00
66.00	06600	PHYSICAL THERAPY	0	625,257		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,426		67.00
68.00	06800	SPEECH PATHOLOGY	0	43,720		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-71,141	746,853		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	538,836		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-331,485	2,029,000		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,724,516		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,051,116		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	404,893		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	260,618		88.03
91.00	09100	EMERGENCY	-1,291,424	2,552,021		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,670,624	41,317,427		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-40,214	2,364,335		192.00
194.00	07950	FOUNDATION / MOBS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,710,838	43,681,762		200.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 11:27 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	509,479	1.00
2.00		0.00	0	0	2.00
	0		0	509,479	
	B - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	236,388	0	1.00
	0		236,388	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	512,532	316,924	1.00
	0		512,532	316,924	
	D - RHC ALLOCATION				
1.00	RURAL HEALTH CLINIC	88.00	164,324	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	111,183	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	64,572	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	25,274	0	4.00
5.00	RURAL HEALTH CLINIC II	88.01	7,338	0	5.00
6.00	RURAL HEALTH CLINIC II	88.01	41,713	0	6.00
7.00	RURAL HEALTH CLINIC IV	88.03	36,063	0	7.00
8.00	RURAL HEALTH CLINIC	88.00	22,721	0	8.00
9.00	RURAL HEALTH CLINIC II	88.01	24,689	0	9.00
10.00	RURAL HEALTH CLINIC II	88.01	18,452	0	10.00
11.00	RURAL HEALTH CLINIC	88.00	37,635	0	11.00
12.00	RURAL HEALTH CLINIC IV	88.03	24,755	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	6,438	0	13.00
14.00	ADMINISTRATIVE & GENERAL	5.00	594,810	0	14.00
15.00	RURAL HEALTH CLINIC II	88.01	9,773	0	15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,774	0	16.00
	0		1,195,514	0	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,539	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	83,669	2.00
	0		0	150,208	
	F - LAUNDRY AND HOUSEKEEPING RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	205,187	1.00
	0		0	205,187	
	G - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	538,836	1.00
	0		0	538,836	
	I - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	531,685	0	1.00
	0		531,685	0	
	J - NURSERY RECLASS				
1.00	NURSERY	43.00	48,780	0	1.00
	0		48,780	0	
	K - EKG RECLASSIFICATION				
1.00	EMERGENCY	91.00	0	5,062	1.00
	0		0	5,062	
500.00	Grand Total: Increases		2,524,899	1,725,696	500.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/27/2022 11:27 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CRNA RECLASS					
1.00	OPERATING ROOM	50.00	0	2,250	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	507,229	0	2.00
	0		0	509,479		
	B - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	236,388	0	0	1.00
	0		236,388	0		
	C - DIETARY RECLASS					
1.00	DIETARY	10.00	512,532	316,924	0	1.00
	0		512,532	316,924		
	D - RHC ALLOCATION					
1.00	NURSING ADMINISTRATION	13.00	275,507	0	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	64,572	0	0	2.00
3.00	NURSING ADMINISTRATION	13.00	32,612	0	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	77,776	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	47,410	0	0	5.00
6.00	RURAL HEALTH CLINIC III	88.02	80,842	0	0	6.00
7.00	RURAL HEALTH CLINIC	88.00	6,438	0	0	7.00
8.00	RURAL HEALTH CLINIC	88.00	347,307	0	0	8.00
9.00	RURAL HEALTH CLINIC II	88.01	74,079	0	0	9.00
10.00	RURAL HEALTH CLINIC IV	88.03	173,424	0	0	10.00
11.00	RURAL HEALTH CLINIC	88.00	9,773	0	0	11.00
12.00	RURAL HEALTH CLINIC	88.00	2,761	0	0	12.00
13.00	RURAL HEALTH CLINIC II	88.01	1,646	0	0	13.00
14.00	RURAL HEALTH CLINIC III	88.02	746	0	0	14.00
15.00	RURAL HEALTH CLINIC IV	88.03	621	0	0	15.00
16.00		0.00	0	0	0	16.00
	0		1,195,514	0		
	E - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	150,208	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	150,208		
	F - LAUNDRY AND HOUSEKEEPING RECLASS					
1.00	HOUSEKEEPING	9.00	0	205,187	0	1.00
	0		0	205,187		
	G - IMPLANTABLE DEVICES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	538,836	0	1.00
	0		0	538,836		
	I - HOSPITALIST RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	531,685	0	0	1.00
	0		531,685	0		
	J - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	48,780	0	0	1.00
	0		48,780	0		
	K - EKG RECLASSIFICATION					
1.00	RESPIRATORY THERAPY	65.00	0	5,062	0	1.00
	0		0	5,062		
500.00	Grand Total: Decreases		2,524,899	1,725,696		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2022 11:27 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	651,198	947,777	0	947,777	0	1.00
2.00	Land Improvements	303,546	0	0	0	-89,984	2.00
3.00	Buildings and Fixtures	6,411,574	2,679,202	0	2,679,202	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,196,806	248,714	0	248,714	0	5.00
6.00	Movable Equipment	3,857,112	1,090,658	0	1,090,658	0	6.00
7.00	HIT designated Assets	115,036	0	0	0	-30,000	7.00
8.00	Subtotal (sum of lines 1-7)	15,535,272	4,966,351	0	4,966,351	-119,984	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,535,272	4,966,351	0	4,966,351	-119,984	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,598,975	0	1.00
2.00	Land Improvements	393,530	0	2.00
3.00	Buildings and Fixtures	9,090,776	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,445,520	0	5.00
6.00	Movable Equipment	4,947,770	0	6.00
7.00	HIT designated Assets	145,036	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,621,607	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,621,607	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/27/2022 11:27 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	958,092	0	267,821	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	634,533	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,592,625	0	267,821	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,225,913		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	634,533		2.00
3.00	Total (sum of lines 1-2)	0	1,860,446		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2022 11:27 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	15,433,869	0	15,433,869	0.757244	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,947,770	0	4,947,770	0.242756	0	2.00
3.00	Total (sum of lines 1-2)	20,381,639	0	20,381,639	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	901,173	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	634,533	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,535,706	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	267,821	66,539	0	0	1,235,533	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	634,533	2.00
3.00	Total (sum of lines 1-2)	267,821	66,539	0	0	1,870,066	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 11:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,637	OPERATION OF PLANT	7.00	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	-1,842,204			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-171,429	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,622	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-64,622	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/27/2022 11:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CPR TRAINING	B	1,005	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC REVENUE - ADMIN	B	-3,905	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	AHA DUES	A	-2,673	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-1,175	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-132,479	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-40,982	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	GIFT CARD USAGE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	340B EXPENSE	A	-331,485	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	CRNA TO MARKET ADJUSTMENT	A	-258,197	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.09	OB ON CALL TIME	B	0	DELIVERY ROOM & LABOR ROOM	52.00	0	33.09
33.10	ORTHO CLINIC - START-UP COSTS	A	-40,214	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.10
33.11	HOSPITAL ASSESSMENT FEE	A	-2,727,129	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	BOND AMORTIZATION EXPENSE ADJUSTMENT	A	15,244	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	MISC EXPENSE - ADMIN	A	-12	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.16	INUSRANCE PROCEEDS - CAPITAL	B	-31,181	CAP REL COSTS-BLDG & FIXT	1.00	9	33.16
33.17	REBATES	B	-71,141	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,710,838				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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2022 11:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	580,366	539,740	40,626	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	11,040	11,040	0	0	0	2.00
3.00	91.00	EMERGENCY	1,844,891	1,291,424	553,467	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,436,297	1,842,204	594,093		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	539,740		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	11,040		2.00
3.00	91.00	EMERGENCY	0	0	0	1,291,424		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,842,204		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,235,533	1,235,533				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	634,533		634,533			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,592,114	0	0	4,592,114		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,849,134	107,336	44,854	622,315	7,623,639	5.00
7.00	00700	OPERATION OF PLANT	1,729,598	161,285	67,398	138,379	2,096,660	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	205,453	8,586	3,588	0	217,627	8.00
9.00	00900	HOUSEKEEPING	451,487	8,569	3,581	63,642	527,279	9.00
10.00	01000	DIETARY	190,284	46,400	19,390	23,505	279,579	10.00
11.00	01100	CAFETERIA	593,405	46,400	19,390	102,457	761,652	11.00
13.00	01300	NURSING ADMINISTRATION	928,544	8,433	3,524	146,954	1,087,455	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,673	58,148	24,299	0	128,120	14.00
15.00	01500	PHARMACY	727,623	21,831	9,123	125,314	883,891	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	294,837	18,125	7,574	52,850	373,386	16.00
17.00	01700	SOCIAL SERVICE	271,221	4,863	2,032	50,167	328,283	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	251,282	0	0	0	251,282	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,946,877	288,276	120,465	636,495	3,992,113	30.00
31.00	03100	INTENSIVE CARE UNIT	619,677	45,567	19,041	113,908	798,193	31.00
43.00	04300	NURSERY	53,620	6,444	2,693	9,751	72,508	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	710,887	83,380	34,843	110,080	939,190	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,644	3,503	1,464	168	6,779	52.00
53.00	05300	ANESTHESIOLOGY	151,290	0	0	0	151,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,799,340	77,429	32,356	205,997	2,115,122	54.00
60.00	06000	LABORATORY	3,073,798	44,393	18,551	177,053	3,313,795	60.00
65.00	06500	RESPIRATORY THERAPY	804,317	1,989	831	146,072	953,209	65.00
66.00	06600	PHYSICAL THERAPY	625,257	15,353	6,416	109,139	756,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,426	15,353	6,416	35,654	235,849	67.00
68.00	06800	SPEECH PATHOLOGY	43,720	8,229	3,439	8,740	64,128	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,853	0	0	0	746,853	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	538,836	0	0	0	538,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,029,000	13,058	5,457	52,702	2,100,217	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,724,516	0	43,845	469,711	4,238,072	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,051,116	0	25,535	139,606	1,216,257	88.01
88.02	08802	RURAL HEALTH CLINIC III	404,893	0	21,542	46,874	473,309	88.02
88.03	08803	RURAL HEALTH CLINIC IV	260,618	0	27,304	26,234	314,156	88.03
91.00	09100	EMERGENCY	2,552,021	96,540	40,342	584,502	3,273,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,317,427	1,189,490	615,293	4,198,269	40,858,299	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,727	1,975	0	6,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,364,335	41,316	17,265	393,845	2,816,761	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	43,681,762	1,235,533	634,533	4,592,114	43,681,762	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,623,639					5.00
7.00	00700	OPERATION OF PLANT	443,288	2,539,948				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,012	17,449	281,088			8.00
9.00	00900	HOUSEKEEPING	111,480	17,415	0	656,174		9.00
10.00	01000	DIETARY	59,110	94,295	0	0	432,984	10.00
11.00	01100	CAFETERIA	161,033	94,295	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	229,916	17,138	0	335	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,088	118,171	0	0	0	14.00
15.00	01500	PHARMACY	186,878	44,366	0	19,524	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,944	36,833	0	670	0	16.00
17.00	01700	SOCIAL SERVICE	69,408	9,882	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	53,128	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	844,036	585,842	61,299	208,224	303,092	30.00
31.00	03100	INTENSIVE CARE UNIT	168,759	92,602	17,459	73,150	129,892	31.00
43.00	04300	NURSERY	15,330	13,096	0	14,412	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,569	169,447	27,355	69,128	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,433	7,118	0	9,217	0	52.00
53.00	05300	ANESTHESIOLOGY	31,987	0	0	1,676	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	447,192	157,354	51,528	19,607	0	54.00
60.00	06000	LABORATORY	700,622	90,218	0	27,819	0	60.00
65.00	06500	RESPIRATORY THERAPY	201,533	4,043	70	8,714	0	65.00
66.00	06600	PHYSICAL THERAPY	159,873	31,201	52,403	24,300	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,865	31,201	17,236	3,854	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,558	16,724	0	503	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,904	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,924	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	444,040	26,537	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	896,053	213,226	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	257,148	124,183	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	100,070	104,764	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	66,421	132,787	0	0	0	88.03
91.00	09100	EMERGENCY	692,083	196,191	53,738	145,211	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,026,685	2,446,378	281,088	626,344	432,984	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,417	9,606	0	2,849	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	595,537	83,964	0	20,278	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	6,703	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,623,639	2,539,948	281,088	656,174	432,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,016,980					11.00
13.00	01300	NURSING ADMINISTRATION	72,676	1,407,520				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	273,379			14.00
15.00	01500	PHARMACY	42,195	0	737	1,177,591		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,947	0	84	0	526,864	16.00
17.00	01700	SOCIAL SERVICE	16,645	0	230	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	238,276	755,173	9,557	0	93,747	30.00
31.00	03100	INTENSIVE CARE UNIT	40,287	123,932	1,368	0	24,231	31.00
43.00	04300	NURSERY	3,287	0	0	0	3,178	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,617	152,537	4,268	0	59,453	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53	0	0	0	3,708	52.00
53.00	05300	ANESTHESIOLOGY	0	0	259	0	530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,823	0	3,191	0	31,117	54.00
60.00	06000	LABORATORY	112,326	0	110,977	0	79,579	60.00
65.00	06500	RESPIRATORY THERAPY	59,900	0	3,887	0	16,816	65.00
66.00	06600	PHYSICAL THERAPY	48,556	0	639	0	5,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,966	0	0	0	3,443	67.00
68.00	06800	SPEECH PATHOLOGY	4,453	0	0	0	1,589	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	75,061	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	49,445	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,214	0	254	1,177,591	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	5,164	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	5,164	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	5,164	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	5,164	88.03
91.00	09100	EMERGENCY	122,239	375,878	7,557	0	183,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	973,460	1,407,520	267,514	1,177,591	526,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,520	0	5,865	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,016,980	1,407,520	273,379	1,177,591	526,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	424,448					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	304,410				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	236,041	0	7,327,400	0	7,327,400	30.00
31.00	03100	INTENSIVE CARE UNIT	65,625	0	1,535,498	0	1,535,498	31.00
43.00	04300	NURSERY	0	0	121,811	0	121,811	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,669,564	0	1,669,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,058	0	29,366	0	29,366	52.00
53.00	05300	ANESTHESIOLOGY	0	304,410	490,152	0	490,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,925,934	0	2,925,934	54.00
60.00	06000	LABORATORY	0	0	4,435,336	0	4,435,336	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,248,172	0	1,248,172	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,078,831	0	1,078,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	351,414	0	351,414	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	100,955	0	100,955	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	979,818	0	979,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	702,205	0	702,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,763,853	0	3,763,853	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	5,352,515	0	5,352,515	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,602,752	0	1,602,752	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	683,307	0	683,307	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	518,528	0	518,528	88.03
91.00	09100	EMERGENCY	121,724	0	5,171,149	0	5,171,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	424,448	304,410	40,088,560	0	40,088,560	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	20,574	0	20,574	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,565,925	0	3,565,925	192.00
194.00	07950	FOUNDATION / MOBS	0	0	6,703	0	6,703	194.00
200.00		Cross Foot Adjustments			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)	424,448	304,410	43,681,762	0	43,681,762	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	107,336	44,854	152,190	0	5.00
7.00	00700	OPERATION OF PLANT	0	161,285	67,398	228,683	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,586	3,588	12,174	0	8.00
9.00	00900	HOUSEKEEPING	0	8,569	3,581	12,150	0	9.00
10.00	01000	DIETARY	0	46,400	19,390	65,790	0	10.00
11.00	01100	CAFETERIA	0	46,400	19,390	65,790	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,433	3,524	11,957	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,148	24,299	82,447	0	14.00
15.00	01500	PHARMACY	0	21,831	9,123	30,954	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,125	7,574	25,699	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,863	2,032	6,895	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	288,276	120,465	408,741	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	45,567	19,041	64,608	0	31.00
43.00	04300	NURSERY	0	6,444	2,693	9,137	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	83,380	34,843	118,223	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,503	1,464	4,967	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,429	32,356	109,785	0	54.00
60.00	06000	LABORATORY	0	44,393	18,551	62,944	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,989	831	2,820	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,353	6,416	21,769	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,353	6,416	21,769	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,229	3,439	11,668	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,058	5,457	18,515	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	43,845	43,845	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	25,535	25,535	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	21,542	21,542	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	27,304	27,304	0	88.03
91.00	09100	EMERGENCY	0	96,540	40,342	136,882	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,189,490	615,293	1,804,783	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,727	1,975	6,702	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,316	17,265	58,581	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	0	1,235,533	634,533	1,870,066	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	152,190					5.00
7.00	00700	OPERATION OF PLANT	8,850	237,533				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	919	1,632	14,725			8.00
9.00	00900	HOUSEKEEPING	2,226	1,629	0	16,005		9.00
10.00	01000	DIETARY	1,180	8,818	0	0	75,788	10.00
11.00	01100	CAFETERIA	3,215	8,818	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,590	1,603	0	8	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	541	11,051	0	0	0	14.00
15.00	01500	PHARMACY	3,731	4,149	0	476	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,576	3,445	0	16	0	16.00
17.00	01700	SOCIAL SERVICE	1,386	924	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,061	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,851	54,786	3,211	5,078	53,052	30.00
31.00	03100	INTENSIVE CARE UNIT	3,369	8,660	915	1,784	22,736	31.00
43.00	04300	NURSERY	306	1,225	0	352	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,964	15,847	1,433	1,686	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29	666	0	225	0	52.00
53.00	05300	ANESTHESIOLOGY	639	0	0	41	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,928	14,716	2,699	478	0	54.00
60.00	06000	LABORATORY	13,988	8,437	0	679	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,023	378	4	213	0	65.00
66.00	06600	PHYSICAL THERAPY	3,192	2,918	2,745	593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	996	2,918	903	94	0	67.00
68.00	06800	SPEECH PATHOLOGY	271	1,564	0	12	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,152	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,274	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,865	2,482	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,875	19,941	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,134	11,613	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,998	9,797	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,326	12,418	0	0	0	88.03
91.00	09100	EMERGENCY	13,817	18,348	2,815	3,542	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,272	228,783	14,725	15,277	75,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28	898	0	69	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,890	7,852	0	495	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	164	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	152,190	237,533	14,725	16,005	75,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	77,823					11.00
13.00	01300	NURSING ADMINISTRATION	5,561	23,719				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	94,039			14.00
15.00	01500	PHARMACY	3,229	0	254	42,793		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,827	0	29	0	33,592	16.00
17.00	01700	SOCIAL SERVICE	1,274	0	79	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	18,234	12,727	3,288	0	5,977	30.00
31.00	03100	INTENSIVE CARE UNIT	3,083	2,088	471	0	1,545	31.00
43.00	04300	NURSERY	251	0	0	0	203	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,797	2,570	1,468	0	3,791	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4	0	0	0	236	52.00
53.00	05300	ANESTHESIOLOGY	0	0	89	0	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,715	0	1,098	0	1,984	54.00
60.00	06000	LABORATORY	8,596	0	38,174	0	5,074	60.00
65.00	06500	RESPIRATORY THERAPY	4,584	0	1,337	0	1,072	65.00
66.00	06600	PHYSICAL THERAPY	3,716	0	220	0	363	66.00
67.00	06700	OCCUPATIONAL THERAPY	763	0	0	0	220	67.00
68.00	06800	SPEECH PATHOLOGY	341	0	0	0	101	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25,820	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,008	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,164	0	87	42,793	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	329	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	329	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	329	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	329	88.03
91.00	09100	EMERGENCY	9,354	6,334	2,599	0	11,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,493	23,719	92,021	42,793	33,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,330	0	2,018	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,823	23,719	94,039	42,793	33,592	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	10,558					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,061				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,872		587,817	0	587,817	30.00
31.00	03100	INTENSIVE CARE UNIT	1,632		110,891	0	110,891	31.00
43.00	04300	NURSERY	0		11,474	0	11,474	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		152,779	0	152,779	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26		6,153	0	6,153	52.00
53.00	05300	ANESTHESIOLOGY	0		803	0	803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		147,403	0	147,403	54.00
60.00	06000	LABORATORY	0		137,892	0	137,892	60.00
65.00	06500	RESPIRATORY THERAPY	0		14,431	0	14,431	65.00
66.00	06600	PHYSICAL THERAPY	0		35,516	0	35,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		27,663	0	27,663	67.00
68.00	06800	SPEECH PATHOLOGY	0		13,957	0	13,957	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		28,972	0	28,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		19,282	0	19,282	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73,906	0	73,906	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		81,990	0	81,990	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		42,611	0	42,611	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		33,666	0	33,666	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		41,377	0	41,377	88.03
91.00	09100	EMERGENCY	3,028		208,395	0	208,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,558	0	1,776,978	0	1,776,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		7,697	0	7,697	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		84,166	0	84,166	192.00
194.00	07950	FOUNDATION / MOBS	0		164	0	164	194.00
200.00		Cross Foot Adjustments		1,061	1,061	0	1,061	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,558	1,061	1,870,066	0	1,870,066	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,668					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		89,308				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	22,971,603			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,313	6,313	3,113,068	-7,623,639	36,058,123	5.00
7.00	00700	OPERATION OF PLANT	9,486	9,486	692,226	0	2,096,660	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	505	0	0	217,627	8.00
9.00	00900	HOUSEKEEPING	504	504	318,364	0	527,279	9.00
10.00	01000	DIETARY	2,729	2,729	117,579	0	279,579	10.00
11.00	01100	CAFETERIA	2,729	2,729	512,532	0	761,652	11.00
13.00	01300	NURSING ADMINISTRATION	496	496	735,122	0	1,087,455	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	3,420	0	0	128,120	14.00
15.00	01500	PHARMACY	1,284	1,284	626,872	0	883,891	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	264,376	0	373,386	16.00
17.00	01700	SOCIAL SERVICE	286	286	250,953	0	328,283	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	251,282	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	16,955	3,184,018	0	3,992,113	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	569,813	0	798,193	31.00
43.00	04300	NURSERY	379	379	48,780	0	72,508	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	4,904	550,663	0	939,190	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	206	841	0	6,779	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	151,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	1,030,478	0	2,115,122	54.00
60.00	06000	LABORATORY	2,611	2,611	885,689	0	3,313,795	60.00
65.00	06500	RESPIRATORY THERAPY	117	117	730,710	0	953,209	65.00
66.00	06600	PHYSICAL THERAPY	903	903	545,958	0	756,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	903	178,357	0	235,849	67.00
68.00	06800	SPEECH PATHOLOGY	484	484	43,720	0	64,128	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	746,853	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	538,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	768	263,639	0	2,100,217	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,171	2,349,682	0	4,238,072	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,594	698,367	0	1,216,257	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,032	234,482	0	473,309	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,843	131,231	0	314,156	88.03
91.00	09100	EMERGENCY	5,678	5,678	2,923,913	0	3,273,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,960	86,600	21,001,433	-7,623,639	33,234,660	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	0	0	6,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,430	2,430	1,970,170	0	2,816,761	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,235,533	634,533	4,592,114		7,623,639	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.002436	7.104996	0.199904		0.211426	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		152,190	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004221	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	73,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	505	20,222				8.00
9.00	00900	HOUSEKEEPING	504	0	195,775			9.00
10.00	01000	DIETARY	2,729	0	0	11,807		10.00
11.00	01100	CAFETERIA	2,729	0	0	0	19,185	11.00
13.00	01300	NURSING ADMINISTRATION	496	0	100	0	1,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,420	0	0	0	0	14.00
15.00	01500	PHARMACY	1,284	0	5,825	0	796	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	200	0	697	16.00
17.00	01700	SOCIAL SERVICE	286	0	0	0	314	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,955	4,410	62,125	8,265	4,495	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	1,256	21,825	3,542	760	31.00
43.00	04300	NURSERY	379	0	4,300	0	62	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,904	1,968	20,625	0	936	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206	0	2,750	0	1	52.00
53.00	05300	ANESTHESIOLOGY	0	0	500	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	3,707	5,850	0	1,902	54.00
60.00	06000	LABORATORY	2,611	0	8,300	0	2,119	60.00
65.00	06500	RESPIRATORY THERAPY	117	5	2,600	0	1,130	65.00
66.00	06600	PHYSICAL THERAPY	903	3,770	7,250	0	916	66.00
67.00	06700	OCCUPATIONAL THERAPY	903	1,240	1,150	0	188	67.00
68.00	06800	SPEECH PATHOLOGY	484	0	150	0	84	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	0	287	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,171	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,594	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,032	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,843	0	0	0	0	88.03
91.00	09100	EMERGENCY	5,678	3,866	43,325	0	2,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,801	20,222	186,875	11,807	18,364	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	850	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,430	0	6,050	0	821	192.00
194.00	07950	FOUNDATION / MOBS	0	0	2,000	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,539,948	281,088	656,174	432,984	1,016,980	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.552885	13.900109	3.351674	36.671805	53.009122	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	237,533	14,725	16,005	75,788	77,823	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.231346	0.728167	0.081752	6.418904	4.056450	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	179,648					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,979,203				14.00
15.00	01500	PHARMACY	0	8,037	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	913	0	99,475		16.00
17.00	01700	SOCIAL SERVICE	0	2,508	0	0	401	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,386	104,151	0	17,700	223	30.00
31.00	03100	INTENSIVE CARE UNIT	15,818	14,906	0	4,575	62	31.00
43.00	04300	NURSERY	0	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,469	46,514	0	11,225	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	700	1	52.00
53.00	05300	ANESTHESIOLOGY	0	2,821	0	100	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,776	0	5,875	0	54.00
60.00	06000	LABORATORY	0	1,209,392	0	15,025	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	42,356	0	3,175	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,962	0	1,075	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	650	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	300	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	817,994	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	538,836	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,769	100	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	975	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	975	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	975	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	975	0	88.03
91.00	09100	EMERGENCY	47,975	82,350	0	34,575	115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,648	2,915,285	100	99,475	401	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	63,918	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,407,520	273,379	1,177,591	526,864	424,448	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.834877	0.091762	11,775.910000	5.296446	1,058.473815	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,719	94,039	42,793	33,592	10,558	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.132030	0.031565	427.930000	0.337693	26.329177	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/27/2022 11:27 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	88.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	304,410	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,044.100000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,061	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.610000	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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,327,400		7,327,400	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,535,498		1,535,498	0	0	31.00
43.00	04300	NURSERY	121,811		121,811	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,669,564		1,669,564	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,366		29,366	0	0	52.00
53.00	05300	ANESTHESIOLOGY	490,152		490,152	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,934		2,925,934	0	0	54.00
60.00	06000	LABORATORY	4,435,336		4,435,336	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,248,172	0	1,248,172	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,078,831	0	1,078,831	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,414	0	351,414	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	100,955	0	100,955	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	979,818		979,818	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	702,205		702,205	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,763,853		3,763,853	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,352,515		5,352,515	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,602,752		1,602,752	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	683,307		683,307	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	518,528		518,528	0	0	88.03
91.00	09100	EMERGENCY	5,171,149		5,171,149	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,225,964		2,225,964		0	92.00
200.00		Subtotal (see instructions)	42,314,524	0	42,314,524	0	0	200.00
201.00		Less Observation Beds	2,225,964		2,225,964		0	201.00
202.00		Total (see instructions)	40,088,560	0	40,088,560	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,433,522		3,433,522			30.00
31.00	03100	INTENSIVE CARE UNIT	813,800		813,800			31.00
43.00	04300	NURSERY	188,518		188,518			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	904,626	5,047,271	5,951,897	0.280510	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,684	3,474	140,158	0.209521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	287,936	1,029,595	1,317,531	0.372023	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,357	23,885,227	24,696,584	0.118475	0.000000	54.00
60.00	06000	LABORATORY	1,491,173	20,893,404	22,384,577	0.198142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,449,985	3,006,116	4,456,101	0.280104	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	395,091	3,309,516	3,704,607	0.291213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,212	1,032,467	1,169,679	0.300436	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,626	173,512	199,138	0.506960	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,429,717	2,327,320	3,757,037	0.260795	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,122	377,484	579,606	1.211521	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,350,386	11,856,580	15,206,966	0.247508	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,569,575	4,569,575			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,302,515	1,302,515			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	441,720	441,720			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	585,614	585,614			88.03
91.00	09100	EMERGENCY	918,781	24,150,422	25,069,203	0.206275	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	222,220	1,602,051	1,824,271	1.220194	0.000000	92.00
200.00		Subtotal (see instructions)	16,198,756	105,593,863	121,792,619			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,198,756	105,593,863	121,792,619			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,327,400		7,327,400	0	7,327,400	30.00
31.00	03100	INTENSIVE CARE UNIT	1,535,498		1,535,498	0	1,535,498	31.00
43.00	04300	NURSERY	121,811		121,811	0	121,811	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,669,564		1,669,564	0	1,669,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,366		29,366	0	29,366	52.00
53.00	05300	ANESTHESIOLOGY	490,152		490,152	0	490,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,934		2,925,934	0	2,925,934	54.00
60.00	06000	LABORATORY	4,435,336		4,435,336	0	4,435,336	60.00
65.00	06500	RESPIRATORY THERAPY	1,248,172	0	1,248,172	0	1,248,172	65.00
66.00	06600	PHYSICAL THERAPY	1,078,831	0	1,078,831	0	1,078,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,414	0	351,414	0	351,414	67.00
68.00	06800	SPEECH PATHOLOGY	100,955	0	100,955	0	100,955	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	979,818		979,818	0	979,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	702,205		702,205	0	702,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,763,853		3,763,853	0	3,763,853	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,352,515		5,352,515	0	5,352,515	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,602,752		1,602,752	0	1,602,752	88.01
88.02	08802	RURAL HEALTH CLINIC III	683,307		683,307	0	683,307	88.02
88.03	08803	RURAL HEALTH CLINIC IV	518,528		518,528	0	518,528	88.03
91.00	09100	EMERGENCY	5,171,149		5,171,149	0	5,171,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,225,964		2,225,964		2,225,964	92.00
200.00		Subtotal (see instructions)	42,314,524	0	42,314,524	0	42,314,524	200.00
201.00		Less Observation Beds	2,225,964		2,225,964		2,225,964	201.00
202.00		Total (see instructions)	40,088,560	0	40,088,560	0	40,088,560	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,433,522		3,433,522			30.00
31.00	03100	INTENSIVE CARE UNIT	813,800		813,800			31.00
43.00	04300	NURSERY	188,518		188,518			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	904,626	5,047,271	5,951,897	0.280510	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,684	3,474	140,158	0.209521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	287,936	1,029,595	1,317,531	0.372023	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,357	23,885,227	24,696,584	0.118475	0.000000	54.00
60.00	06000	LABORATORY	1,491,173	20,893,404	22,384,577	0.198142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,449,985	3,006,116	4,456,101	0.280104	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	395,091	3,309,516	3,704,607	0.291213	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,212	1,032,467	1,169,679	0.300436	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,626	173,512	199,138	0.506960	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,429,717	2,327,320	3,757,037	0.260795	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,122	377,484	579,606	1.211521	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,350,386	11,856,580	15,206,966	0.247508	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,569,575	4,569,575	1.171338	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,302,515	1,302,515	1.230506	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	441,720	441,720	1.546923	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	585,614	585,614	0.885443	0.000000	88.03
91.00	09100	EMERGENCY	918,781	24,150,422	25,069,203	0.206275	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	222,220	1,602,051	1,824,271	1.220194	0.000000	92.00
200.00		Subtotal (see instructions)	16,198,756	105,593,863	121,792,619			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,198,756	105,593,863	121,792,619			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,779	5,951,897	0.025669	228,269	5,859	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,153	140,158	0.043900	0	0	52.00
53.00	05300	ANESTHESIOLOGY	803	1,317,531	0.000609	121,701	74	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,403	24,696,584	0.005969	386,230	2,305	54.00
60.00	06000	LABORATORY	137,892	22,384,577	0.006160	664,453	4,093	60.00
65.00	06500	RESPIRATORY THERAPY	14,431	4,456,101	0.003238	693,808	2,247	65.00
66.00	06600	PHYSICAL THERAPY	35,516	3,704,607	0.009587	146,666	1,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,663	1,169,679	0.023650	18,929	448	67.00
68.00	06800	SPEECH PATHOLOGY	13,957	199,138	0.070087	10,370	727	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,972	3,757,037	0.007711	204,999	1,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,282	579,606	0.033267	118,626	3,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,906	15,206,966	0.004860	1,815,977	8,826	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,990	4,569,575	0.017943	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	42,611	1,302,515	0.032714	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	33,666	441,720	0.076216	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	41,377	585,614	0.070656	0	0	88.03
91.00	09100	EMERGENCY	208,395	25,069,203	0.008313	61,750	513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	178,571	1,824,271	0.097886	1,406	138	92.00
200.00		Total (lines 50 through 199)	1,245,367	117,356,779		4,473,184	32,163	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	304,410	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	304,410	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,951,897	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	140,158	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	304,410	0	1,317,531	0.231046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,696,584	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	22,384,577	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,456,101	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,704,607	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,169,679	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	199,138	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,757,037	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	579,606	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,206,966	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,569,575	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,302,515	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	441,720	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	585,614	0.000000	88.03
91.00	09100	EMERGENCY	0	0	0	25,069,203	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,824,271	0.000000	92.00
200.00		Total (lines 50 through 199)	0	304,410	0	117,356,779		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	228,269	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	121,701	28,119	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	386,230	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	664,453	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	693,808	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	146,666	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,929	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,370	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	204,999	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	118,626	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,815,977	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
91.00	09100	EMERGENCY	0.000000	61,750	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,406	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,473,184	28,119	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.280510	0	1,095,454	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209521	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.372023	0	464,337	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118475	0	6,445,850	0	0	54.00
60.00	06000	LABORATORY	0.198142	0	6,215,343	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.280104	0	828,156	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.291213	0	1,179,998	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300436	0	343,030	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.506960	0	45,811	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260795	0	501,006	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.211521	0	113,845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247508	0	4,926,145	1,401	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.206275	0	6,042,583	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.220194	0	456,559	0	0	92.00
200.00		Subtotal (see instructions)		0	28,658,117	1,401	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	28,658,117	1,401	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	307,286	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	172,744	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	763,672	0		54.00
60.00	06000	LABORATORY	1,231,520	0		60.00
65.00	06500	RESPIRATORY THERAPY	231,970	0		65.00
66.00	06600	PHYSICAL THERAPY	343,631	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	103,059	0		67.00
68.00	06800	SPEECH PATHOLOGY	23,224	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,660	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	137,926	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,219,260	347		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
91.00	09100	EMERGENCY	1,246,434	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,091	0		92.00
200.00		Subtotal (see instructions)	6,468,477	347		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,468,477	347		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.280510	0	684,370	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209521	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.372023	0	11,594	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118475	0	2,000,003	0	0	54.00
60.00	06000	LABORATORY	0.198142	0	2,198,033	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.280104	0	290,568	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.291213	0	158,575	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300436	0	34,844	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.506960	0	85,792	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260795	0	176,681	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.211521	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247508	0	558,955	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.206275	0	3,233,381	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.220194	0	159,315	0	0	92.00
200.00		Subtotal (see instructions)		0	9,592,111	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	9,592,111	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	191,973	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	4,313	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,950	0		54.00
60.00	06000	LABORATORY	435,523	0		60.00
65.00	06500	RESPIRATORY THERAPY	81,389	0		65.00
66.00	06600	PHYSICAL THERAPY	46,179	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,468	0		67.00
68.00	06800	SPEECH PATHOLOGY	43,493	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,078	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,346	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
91.00	09100	EMERGENCY	666,966	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,395	0		92.00
200.00		Subtotal (see instructions)	2,096,073	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,096,073	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,407	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,022	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,987	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,030	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)	306	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,327,400	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	828,016	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,499,384	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)	6,499,384	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,150.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,215,211	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)	2,215,211	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,535,498	263	5,838.40	156	910,790	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,195,819	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,321,820	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)	658,111	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	658,111	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)	1,035	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,150.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,225,964	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	587,817	7,327,400	0.080222	2,225,964	178,571	90.00
91.00	Nursing Program cost	0	7,327,400	0.000000	2,225,964	0	91.00
92.00	Allied health cost	0	7,327,400	0.000000	2,225,964	0	92.00
93.00	All other Medical Education	0	7,327,400	0.000000	2,225,964	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 11:27 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,407	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,022	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,987	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	33	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	120	15.00
16.00	Nursery days (title V or XIX only)	6	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,327,400	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	828,016	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,499,384	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)	6,499,384	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,150.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	70,973	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)	70,973	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	121,811	120	1,015.09	6	6,091	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,535,498	263	5,838.40	5	29,192	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)	179,392	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	285,648	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,035	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,150.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,225,964	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	587,817	7,327,400	0.080222	2,225,964	178,571	90.00
91.00	Nursing Program cost	0	7,327,400	0.000000	2,225,964	0	91.00
92.00	Allied health cost	0	7,327,400	0.000000	2,225,964	0	92.00
93.00	All other Medical Education	0	7,327,400	0.000000	2,225,964	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,604,694		30.00
31.00	03100	INTENSIVE CARE UNIT		405,448		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280510	228,269	64,032	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209521	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.372023	121,701	45,276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118475	386,230	45,759	54.00
60.00	06000	LABORATORY	0.198142	664,453	131,656	60.00
65.00	06500	RESPIRATORY THERAPY	0.280104	693,808	194,338	65.00
66.00	06600	PHYSICAL THERAPY	0.291213	146,666	42,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300436	18,929	5,687	67.00
68.00	06800	SPEECH PATHOLOGY	0.506960	10,370	5,257	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260795	204,999	53,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.211521	118,626	143,718	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247508	1,815,977	449,469	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.206275	61,750	12,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.220194	1,406	1,716	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,473,184	1,195,819	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,473,184		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280510	2,419	679	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209521	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.372023	1,379	513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118475	12,707	1,505	54.00
60.00	06000	LABORATORY	0.198142	33,729	6,683	60.00
65.00	06500	RESPIRATORY THERAPY	0.280104	53,211	14,905	65.00
66.00	06600	PHYSICAL THERAPY	0.291213	127,970	37,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300436	83,078	24,960	67.00
68.00	06800	SPEECH PATHOLOGY	0.506960	5,124	2,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260795	34,214	8,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.211521	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247508	124,021	30,696	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.206275	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.220194	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		477,852	128,729	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		477,852		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/27/2022 11:27 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		163,590		30.00
31.00	03100	INTENSIVE CARE UNIT		59,800		31.00
43.00	04300	NURSERY		146,452		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280510	33,655	9,441	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209521	24,318	5,095	52.00
53.00	05300	ANESTHESIOLOGY	0.372023	7,227	2,689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118475	38,052	4,508	54.00
60.00	06000	LABORATORY	0.198142	142,115	28,159	60.00
65.00	06500	RESPIRATORY THERAPY	0.280104	107,519	30,117	65.00
66.00	06600	PHYSICAL THERAPY	0.291213	8,661	2,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300436	1,432	430	67.00
68.00	06800	SPEECH PATHOLOGY	0.506960	622	315	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260795	68,371	17,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.211521	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247508	188,173	46,574	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.171338	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.230506	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.546923	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.885443	0	0	88.03
91.00	09100	EMERGENCY	0.206275	153,730	31,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.220194	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		773,875	179,392	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		773,875		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part B Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,468,824	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)	6,468,824	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)	6,533,512	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)	40,046	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,504,750	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)	1,988,716	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)	1,988,716	30.00
31.00	Primary payer payments	258	31.00
32.00	Subtotal (line 30 minus line 31)	1,988,458	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,007,328	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	654,763	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,659	36.00
37.00	Subtotal (see instructions)	2,643,221	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)		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)	2,643,221	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		40.03
41.00	Interim payments	3,054,827	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-411,606	43.00
43.01	Balance due provider/program-PARHM (see instructions)		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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,974,555		2,565,327	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	10/04/2021	489,500	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		489,500	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)		3,974,555		3,054,827	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		130,873		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		411,606	6.02
7.00	Total Medicare program liability (see instructions)		4,105,428		2,643,221	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: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		663,817		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		663,817		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		127,181		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		790,998		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: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	664,692	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)	130,016	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	306	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)	794,708	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	794,708	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)	794,708	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,710	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	790,998	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	790,998	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	663,817	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)	127,181	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,321,820	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)	4,321,820	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,365,038	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)	4,365,038	19.00
20.00	Deductibles (exclude professional component)	310,080	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,054,958	22.00
23.00	Coinsurance	1,113	23.00
24.00	Subtotal (line 22 minus line 23)	4,053,845	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	79,359	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	51,583	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,581	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,105,428	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	4,105,428	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,974,555	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	130,873	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 11:27 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	285,648		1.00
2.00	Medical and other services		2,096,073	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	285,648	2,096,073	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	285,648	2,096,073	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	773,875	9,592,111	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	773,875	9,592,111	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	773,875	9,592,111	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	488,227	7,496,038	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	285,648	2,096,073	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	285,648	2,096,073	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	285,648	2,096,073	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	285,648	2,096,073	36.00
37.00	TO ZERO OUT MEDICAID	-285,648	-2,096,073	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/27/2022 11:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	10,742,767	0	0	0	1.00
2.00	Temporary investments	2,516,244	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,617,301	0	0	0	4.00
5.00	Other receivable	1,832,674	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	523,662	0	0	0	7.00
8.00	Prepaid expenses	341,920	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)	21,574,568	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,598,975	0	0	0	12.00
13.00	Land improvements	213,562	0	0	0	13.00
14.00	Accumulated depreciation	-94,160	0	0	0	14.00
15.00	Buildings	9,090,776	0	0	0	15.00
16.00	Accumulated depreciation	-2,128,042	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	4,445,520	0	0	0	19.00
20.00	Accumulated depreciation	-1,927,129	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	5,032,806	0	0	0	23.00
24.00	Accumulated depreciation	-1,626,873	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,605,435	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,259,843	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	7,753	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,267,596	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,447,599	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,787,230	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,230,158	0	0	0	38.00
39.00	Payroll taxes payable	594,557	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,403,317	0	0	0	40.00
41.00	Deferred income	130,554	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,800,609	0	0	0	43.00
44.00	Other current liabilities	2,089,268	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,035,693	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,034,990	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)	15,034,990	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,070,683	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,376,916				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)	11,376,916	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,447,599	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/27/2022 11:27 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,449,172		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		927,744				2.00
3.00	Total (sum of line 1 and line 2)		11,376,916		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)		11,376,916		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)		11,376,916		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: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/27/2022 11:27 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,323,050		3,323,050	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,323,050		3,323,050	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	813,800		813,800	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)	813,800		813,800	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,136,850		4,136,850	17.00
18.00	Ancillary services	13,049,565	106,715,125	119,764,690	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	4,569,575	4,569,575	20.00
20.01	RURAL HEALTH CLINIC II	0	1,302,515	1,302,515	20.01
20.02	RURAL HEALTH CLINIC III	0	441,720	441,720	20.02
20.03	RURAL HEALTH CLINIC IV	0	585,614	585,614	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,186,415	113,614,549	130,800,964	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		49,392,600		29.00
30.00	BAD DEBT EXPENSE	6,947,031			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)		6,947,031		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)		56,339,631		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/27/2022 11:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	130,800,964	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,632,740	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,168,224	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,339,631	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,171,407	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER GRANTS, PURCHASING DISCOUNTS	2,583,247	24.00
24.50	COVID-19 PHE Funding	4,515,904	24.50
25.00	Total other income (sum of lines 6-24)	7,099,151	25.00
26.00	Total (line 5 plus line 25)	927,744	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)	927,744	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,543,783	0	2,543,783	-1,501,390	1,042,393	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	686,437	686,437	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	76,355	76,355	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	655,547	655,547	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,543,783	0	2,543,783	-83,051	2,460,732	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	936,560	936,560	0	936,560	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	936,560	936,560	0	936,560	14.00
15.00	Medical Supplies	0	133,237	133,237	0	133,237	15.00
16.00	Transportation (Health Care Staff)	0	30,978	30,978	0	30,978	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	164,215	164,215	0	164,215	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,543,783	1,100,775	3,644,558	-83,051	3,561,507	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	21,525	21,525	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	21,525	21,525	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	220,503	220,503	0	220,503	29.00
30.00	Administrative Costs	0	53,556	53,556	61,526	115,082	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	274,059	274,059	61,526	335,585	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,543,783	1,374,834	3,918,617	0	3,918,617	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-164,147	878,246		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	25,101	711,538		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	-55,055	21,300		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	655,547		9.00
10.00	Subtotal (sum of lines 1 through 9)	-194,101	2,266,631		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	936,560		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	936,560		14.00
15.00	Medical Supplies	0	133,237		15.00
16.00	Transportation (Health Care Staff)	0	30,978		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	164,215		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-194,101	3,367,406		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	21,525		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	21,525		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	220,503		29.00
30.00	Administrative Costs	0	115,082		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	335,585		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-194,101	3,724,516		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC II

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	625,516	0	625,516	-262,442	363,074	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	137,589	137,589	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	113,273	113,273	9.00
10.00	Subtotal (sum of lines 1 through 9)	625,516	0	625,516	-11,580	613,936	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	167,660	167,660	0	167,660	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	167,660	167,660	0	167,660	14.00
15.00	Medical Supplies	0	57,596	57,596	0	57,596	15.00
16.00	Transportation (Health Care Staff)	0	10,729	10,729	0	10,729	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	68,325	68,325	0	68,325	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	625,516	235,985	861,501	-11,580	849,921	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	11,580	11,580	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	11,580	11,580	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	100,145	100,145	0	100,145	29.00
30.00	Administrative Costs	0	16,619	16,619	0	16,619	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,764	116,764	0	116,764	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	625,516	352,749	978,265	0	978,265	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-21,369	341,705		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	27,818	165,407		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	66,402	66,402		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	113,273		9.00
10.00	Subtotal (sum of lines 1 through 9)	72,851	686,787		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	167,660		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	167,660		14.00
15.00	Medical Supplies	0	57,596		15.00
16.00	Transportation (Health Care Staff)	0	10,729		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	68,325		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	72,851	922,772		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	11,580		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,580		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	100,145		29.00
30.00	Administrative Costs	0	16,619		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,764		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	72,851	1,051,116		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC III

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	251,498	0	251,498	-251,499	-1	1.00
2.00	Physician Assistant	0	0	0	143,340	143,340	2.00
3.00	Nurse Practitioner	0	0	0	102,488	102,488	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	-1,195	-1,195	9.00
10.00	Subtotal (sum of lines 1 through 9)	251,498	0	251,498	-6,866	244,632	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	57,824	57,824	0	57,824	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	57,824	57,824	0	57,824	14.00
15.00	Medical Supplies	0	18,423	18,423	0	18,423	15.00
16.00	Transportation (Health Care Staff)	0	699	699	0	699	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,122	19,122	0	19,122	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	251,498	76,946	328,444	-6,866	321,578	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	6,866	6,866	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	6,866	6,866	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	83,368	83,368	0	83,368	29.00
30.00	Administrative Costs	0	10,097	10,097	0	10,097	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,465	93,465	0	93,465	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	251,498	170,411	421,909	0	421,909	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	64,572	64,571		1.00
2.00	Physician Assistant	-398	142,942		2.00
3.00	Nurse Practitioner	-81,190	21,298		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	-1,195		9.00
10.00	Subtotal (sum of lines 1 through 9)	-17,016	227,616		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	57,824		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	57,824		14.00
15.00	Medical Supplies	0	18,423		15.00
16.00	Transportation (Health Care Staff)	0	699		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,122		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-17,016	304,562		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	6,866		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	6,866		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	83,368		29.00
30.00	Administrative Costs	0	10,097		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,465		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,016	404,893		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1317
Component CCN: 15-8538

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

Worksheet M-1

Date/Time Prepared: 5/27/2022 11:27 am

RHC IV

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	244,458	0	244,458	-71,035	173,423	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	69,238	69,238	9.00
10.00	Subtotal (sum of lines 1 through 9)	244,458	0	244,458	-1,797	242,661	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	53,628	53,628	0	53,628	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	53,628	53,628	0	53,628	14.00
15.00	Medical Supplies	0	30,700	30,700	0	30,700	15.00
16.00	Transportation (Health Care Staff)	0	574	574	0	574	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,274	31,274	0	31,274	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	244,458	84,902	329,360	-1,797	327,563	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	1,797	1,797	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,797	1,797	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	34,886	34,886	0	34,886	29.00
30.00	Administrative Costs	0	9,599	9,599	0	9,599	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	44,485	44,485	0	44,485	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	244,458	129,387	373,845	0	373,845	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/27/2022 11:27 am

RHC IV

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-173,423	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	24,755	24,755		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	36,063	36,063		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	69,238		9.00
10.00	Subtotal (sum of lines 1 through 9)	-112,605	130,056		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	53,628		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	53,628		14.00
15.00	Medical Supplies	0	30,700		15.00
16.00	Transportation (Health Care Staff)	0	574		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,274		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-112,605	214,958		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	1,797		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,797		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	34,886		29.00
30.00	Administrative Costs	-622	8,977		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-622	43,863		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-113,227	260,618		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/27/2022 11:27 am

RHC I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.84	4,427	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	6.08	16,574	1	6		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.92	21,001		10	21,001	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	0.36	127			127	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)	10.28	21,128			21,128	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,367,406	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					21,525	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,388,931	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993648	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					335,585	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,627,999	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,963,584	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,963,584	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,951,111	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,318,517	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 Component CCN: 15-8533

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

Worksheet M-2 Date/Time Prepared: 5/27/2022 11:27 am

RHC II

		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	1.51	2,176	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.29	3,084	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.80	5,260		3	5,260	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	0.95	581			581	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.75	5,841			5,841	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)					922,772	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,580	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					934,352	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.987606	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					116,764	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					551,636	15.00
16.00	Total overhead (sum of lines 14 and 15)					668,400	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					668,400	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					660,116	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,582,888	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/27/2022 11:27 am

RHC III

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.26	565	1	0		1.00
2.00	Physician Assistant	0.85	1,273	1	1		2.00
3.00	Nurse Practitioner	0.18	193	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.29	2,031		1	2,031	4.00
5.00	Visiting Nurse	0.98	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.27	2,031			2,031	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)					304,562	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					6,866	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					311,428	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.977953	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					93,465	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					278,414	15.00
16.00	Total overhead (sum of lines 14 and 15)					371,879	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					371,879	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					363,680	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					668,242	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/27/2022 11:27 am

RHC IV

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.25	2,272	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.25	2,272		0	2,272	4.00
5.00	Visiting Nurse	1.41	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.48	383			383	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.14	2,655			2,655	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)	214,958	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	1,797	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	216,755	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.991710	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	43,863	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	257,910	15.00
16.00	Total overhead (sum of lines 14 and 15)	301,773	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	301,773	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	299,271	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	514,229	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	RHC I	

		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)	5,318,517	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	223,916	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	5,094,601	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	21,128	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)	21,128	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	241.13	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	224.22	8.00
9.00	Rate for Program covered visits (see instructions)	241.13	224.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	725	2,719	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	174,819	609,654	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	784,473	16.00
16.01	Total program charges (see instructions)(from contractor's records)		645,483	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		79,757	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		96,931	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.)		499,542	16.04
16.05	Total program cost (see instructions)	0	596,473	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		63,115	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		100,541	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		596,473	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		68,385	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		664,858	22.00
23.00	Allowable bad debts (see instructions)		960	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		624	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		927	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)		665,482	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		577,781	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)		87,701	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8533	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	RHC II	

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,582,888	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	250,939	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,331,949	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	5,841	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)	5,841	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	228.03	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	128.21	8.00
9.00	Rate for Program covered visits (see instructions)	228.03	128.21	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	331	897	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	75,478	115,004	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	190,482	16.00
16.01	Total program charges (see instructions)(from contractor's records)		248,909	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,649	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,558	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.)		121,509	16.04
16.05	Total program cost (see instructions)	0	125,067	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		35,038	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		41,844	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		125,067	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		80,232	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		205,299	22.00
23.00	Allowable bad debts (see instructions)		641	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		417	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		274	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)		205,716	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		109,247	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)		96,469	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8534	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	RHC III	

		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)	668,242	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	44,733	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	623,509	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	2,031	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	2,031	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	307.00	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	233.71	8.00
9.00	Rate for Program covered visits (see instructions)	307.00	233.71	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	78	256	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	23,946	59,830	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	83,776	16.00
16.01	Total program charges (see instructions)(from contractor's records)		67,151	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		993	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,239	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		59,304	16.04
16.05	Total program cost (see instructions)	0	60,543	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,407	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,550	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,543	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,379	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		77,922	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		77,922	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		59,655	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)		18,267	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/27/2022 11:27 am
	Title XVIII	RHC IV	

		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)	514,229	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	182,041	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	332,188	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	2,655	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	2,655	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	125.12	7.00

		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	139.91	8.00
9.00	Rate for Program covered visits (see instructions)	125.12	125.12	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	132	425	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	16,516	53,176	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	69,692	16.00
16.01	Total program charges (see instructions)(from contractor's records)		106,839	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,976	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,289	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.)		39,650	16.04
16.05	Total program cost (see instructions)	0	40,939	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,840	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,205	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		40,939	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,782	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		79,721	22.00
23.00	Allowable bad debts (see instructions)		140	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		91	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		95	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)		79,812	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		48,773	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)		31,039	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: 15-1317 | Component CCN: 15-8535 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | RHC I

		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)	2,266,631	2,266,631	2,266,631	2,266,631	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001331	0.006325	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,017	14,336	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	72,279	52,140	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	75,296	66,476	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,367,406	3,367,406	3,367,406	3,367,406	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,951,111	1,951,111	1,951,111	1,951,111	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.022360	0.019741	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	43,627	38,517	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	118,923	104,993	0	0	10.00
11.00	Total number of injections/infusions (from your records)	399	1,896	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	298.05	55.38	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	86	772	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	25,632	42,753	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		223,916			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)		68,385			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8533 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | RHC II

		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)	686,787	686,787	686,787	686,787	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005705	0.016112	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,918	11,066	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	78,001	53,304	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	81,919	64,370	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	922,772	922,772	922,772	922,772	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	660,116	660,116	660,116	660,116	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.088775	0.069757	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	58,602	46,048	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	140,521	110,418	0	0	10.00
11.00	Total number of injections/infusions (from your records)	416	1,302	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	337.79	84.81	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	116	484	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	39,184	41,048	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		250,939			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)		80,232			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8534 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | RHC III

		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)	227,616	227,616	227,616	227,616	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001800	0.009073	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	410	2,065	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	6,937	10,976	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7,347	13,041	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	304,562	304,562	304,562	304,562	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	363,680	363,680	363,680	363,680	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024123	0.042819	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,773	15,572	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,120	28,613	0	0	10.00
11.00	Total number of injections/infusions (from your records)	51	257	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	316.08	111.33	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	18	105	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,689	11,690	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		44,733			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)		17,379			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1317 | Component CCN: 15-8538 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/27/2022 11:27 am

Title XVIII | RHC IV

		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)	130,056	130,056	130,056	130,056	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005656	0.030529	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	736	3,970	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	32,745	38,646	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	33,481	42,616	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	214,958	214,958	214,958	214,958	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	299,271	299,271	299,271	299,271	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.155756	0.198253	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	46,613	59,331	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	80,094	101,947	0	0	10.00
11.00	Total number of injections/infusions (from your records)	171	923	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	468.39	110.45	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	67	67	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	31,382	7,400	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		182,041			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)		38,782			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1317 Component CCN: 15-8535	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 11:27 am
		RHC I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		577,781	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		577,781	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		87,701	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		665,482	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1317
Component CCN: 15-8533

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

Worksheet M-5

Date/Time Prepared:
5/27/2022 11:27 am

RHC II

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		109,247	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		109,247	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		96,469	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		205,716	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1317 Component CCN: 15-8534	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 11:27 am
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		59,655	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		59,655	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		18,267	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		77,922	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1317 Component CCN: 15-8538	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 11:27 am
		RHC IV	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		48,773	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		48,773	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		31,039	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		79,812	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00