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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 6/24/2022 9:41 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/24/2022 Time: 9:41 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 PERRY COUNTY HOSPITAL (15-1322) 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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	246,559	-546,380	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	166,885	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC - TCC I	0		35,375		0	10.00
10.01	RURAL HEALTH CLINIC II - PCFP	0		11,505		0	10.01
10.02	RURAL HEALTH CLINIC III - 13TH	0		9,192		0	10.02
10.03	RURAL HEALTH CLINIC IV - SPENCER	0		26,419		0	10.03
200.00	Total	0	413,444	-463,889	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 6/24/2022 9:41 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8885 SR 237	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47586	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	O	P	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	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	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	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PERRY CO SURG - 13TH ST	158560	99915		03/24/2021	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	SPENCER CO CLINIC	158562	99915		03/24/2021	N	O	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	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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 6/24/2022 9:41 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.	2	N		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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 6/24/2022 9:41 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.				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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 6/24/2022 9:41 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

		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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	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.	Y	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.	Y	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.	Y	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

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	249,243	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	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

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

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

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

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

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

		Part A	Part B	Title V	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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 6/24/2022 9:41 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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 6/24/2022 9:41 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	R		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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/29/2022	Y	04/29/2022	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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 6/24/2022 9:41 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 6/24/2022 9:41 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 6/24/2022 9:41 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	53,040.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	53,040.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	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	53,040.00	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	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II - PCFP	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III - 13TH	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 6/24/2022 9:41 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)	959	33	2,210			1.00
2.00	HMO and other (see instructions)	335	248				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	824	0	824			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	213			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,783	33	3,247			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	122			13.00
14.00	Total (see instructions)	1,783	33	3,369	0.00	211.45	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	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	2,401	0	14,800	0.00	23.50	26.00
26.01	RURAL HEALTH CLINIC II - PCFP	169	0	1,986	0.00	6.84	26.01
26.02	RURAL HEALTH CLINIC III - 13TH	111	0	4,157	0.00	4.51	26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	271	0	4,009	0.00	6.60	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	252.90	27.00
28.00	Observation Bed Days		12	460			28.00
29.00	Ambulance Trips	838					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	2	37			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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 6/24/2022 9:41 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	253	9	630	1.00
2.00	HMO and other (see instructions)			78	70		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	253	9	630	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	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	0.00					26.00
26.01	RURAL HEALTH CLINIC II - PCFP	0.00					26.01
26.02	RURAL HEALTH CLINIC III - 13TH	0.00					26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	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: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 6/24/2022 9:41 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	109 IN-66	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	TELL CITY	IN	47586	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	20:00	07:00	11.00

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

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

		Y/N	V	XVIII	XIX	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	PERRY	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	20:00	07:00	20:00	07:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 6/24/2022 9:41 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	20:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 6/24/2022 9:41 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	18485 STATE ROAD 37	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD	IN	47551	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:00	07:00	11.00

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

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

		Y/N	V	XVIII	XIX	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	PERRY	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	16:00			07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 6/24/2022 9:41 am
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	148 13TH STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	TELL CITY	IN	47586	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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	PERRY	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	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8562	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 6/24/2022 9:41 am
		RHC IV	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	105 2ND STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROCKPORT	IN	47635	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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	SPENCER		2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 6/24/2022 9:41 am

RHC IV | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 6/24/2022 9:41 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)	0.363884	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,798,139	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	14,958,915	6.00
7.00	Medicaid cost (line 1 times line 6)	5,443,310	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)	1,645,171	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)	1,645,171	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)	485,854	0	485,854	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	176,794	0	176,794	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)	176,794	0	176,794	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,188,670	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	250,032	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	384,665	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,804,005	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	791,082	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	967,876	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,613,047	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 6/24/2022 9:41 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	NEW CAP REL COSTS-BLDG & FIXT		2,553,988	2,553,988	118,580	2,672,568	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,132,939	1,132,939	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	122,796	386,198	508,994	-393	508,601	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	1,472,627	1,238,524	2,711,151	-28,205	2,682,946	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	1,089,553	4,194,296	5,283,849	-26,837	5,257,012	5.02
7.00	00700	OPERATION OF PLANT	264,016	1,681,880	1,945,896	-3,663	1,942,233	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,329	76,329	0	76,329	8.00
9.00	00900	HOUSEKEEPING	273,221	177,053	450,274	0	450,274	9.00
10.00	01000	DIETARY	0	614,145	614,145	-377,912	236,233	10.00
11.00	01100	CAFETERIA	0	0	0	377,519	377,519	11.00
13.00	01300	NURSING ADMINISTRATION	290,304	90,860	381,164	0	381,164	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	191,003	126,426	317,429	-1,525	315,904	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,820,350	3,105,947	5,926,297	-177,517	5,748,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	527,401	1,163,118	1,690,519	-219,155	1,471,364	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	123,564	123,564	0	123,564	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	841,856	618,778	1,460,634	-1,437	1,459,197	54.00
60.00	06000	LABORATORY	749,752	1,513,425	2,263,177	-1,044	2,262,133	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	384	84,594	84,978	0	84,978	62.00
65.00	06500	RESPIRATORY THERAPY	475,629	968,641	1,444,270	-51,394	1,392,876	65.00
66.00	06600	PHYSICAL THERAPY	498,436	111,124	609,560	-504	609,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,731	38,560	200,291	0	200,291	67.00
68.00	06800	SPEECH PATHOLOGY	80,115	14,721	94,836	0	94,836	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	516,559	516,559	285,395	801,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	116,970	116,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,281	2,808,488	2,902,769	-13,442	2,889,327	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	2,078,610	1,145,831	3,224,441	-225,073	2,999,368	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	606,018	402,744	1,008,762	0	1,008,762	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	1,806,169	607,937	2,414,106	-246,494	2,167,612	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	586,991	275,713	862,704	-193,675	669,029	88.03
90.00	09000	CLINIC	293,536	261,560	555,096	15,930	571,026	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	215,248	89,216	304,464	94,463	398,927	90.02
90.03	09003	ORTHOPEDIC CLINIC	86,992	19,718	106,710	-1,451	105,259	90.03
91.00	09100	EMERGENCY	692,751	1,641,249	2,334,000	-2,197	2,331,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	659,657	474,828	1,134,485	-27,126	1,107,359	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,132,939	1,132,939	-1,132,939	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,979,427	28,258,953	45,238,380	-590,187	44,648,193	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	34,881	110,972	145,853	590,187	736,040	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,014,308	28,369,925	45,384,233	0	45,384,233	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,672,568	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	64,420	1,197,359	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	508,601	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-1,074,706	1,608,240	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-118,571	5,138,441	5.02
7.00	00700	OPERATION OF PLANT	-2,018	1,940,215	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,329	8.00
9.00	00900	HOUSEKEEPING	0	450,274	9.00
10.00	01000	DIETARY	-13,269	222,964	10.00
11.00	01100	CAFETERIA	-62,776	314,743	11.00
13.00	01300	NURSING ADMINISTRATION	0	381,164	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,396	312,508	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-97,000	5,651,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-682,677	788,687	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-123,564	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,459,197	54.00
60.00	06000	LABORATORY	0	2,262,133	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	84,978	62.00
65.00	06500	RESPIRATORY THERAPY	-374,319	1,018,557	65.00
66.00	06600	PHYSICAL THERAPY	0	609,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	200,291	67.00
68.00	06800	SPEECH PATHOLOGY	0	94,836	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	801,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	116,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24	2,889,303	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC	0	2,999,368	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	-70	1,008,692	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	2,167,612	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	-38	668,991	88.03
90.00	09000	CLINIC	-26,250	544,776	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	-123,323	275,604	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	105,259	90.03
91.00	09100	EMERGENCY	0	2,331,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-569	1,106,790	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,638,150	42,010,043	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	736,040	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,638,150	42,746,083	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	0	377,519	1.00
	0		0	377,519	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,132,939	1.00
	0		0	1,132,939	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	79,347	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	79,347	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	39,233	1.00
2.00		0.00	0	0	2.00
	0		0	39,233	
	E - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,837	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,837	
	F - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	402,365	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	402,365	
	G - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	116,970	1.00
	0		0	116,970	
	H - WOUND CARE RECLASS				
1.00	WOUND CARE	90.02	99,631	0	1.00
2.00		0.00	0	0	2.00
	0		99,631	0	
	I - RHC RECRUITING EXPENSE RECLASS				
1.00	RURAL HEALTH CLINIC - TCC	88.00	0	8,701	1.00
2.00	RURAL HEALTH CLINIC III - 13TH	88.02	0	15,875	2.00
	0		0	24,576	
	J - IV THERAPY				
1.00	CLINIC	90.00	0	16,886	1.00
	0		0	16,886	
	L - TELL CITY RECLASS				
1.00	RURAL HEALTH CLINIC III - 13TH	88.02	286,593	0	1.00
2.00	RURAL HEALTH CLINIC IV - SPENCER	88.03	2,501	0	2.00
	0		289,094	0	
	M - RHC CERTIFICAITON RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	544,198	200,940	1.00
2.00		0.00	0	0	2.00
	TOTALS		544,198	200,940	
500.00	Grand Total: Increases		932,923	2,394,612	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COST						
1.00	DIETARY	10.00	0	377,519	0		1.00
	0		0	377,519			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,132,939	11		1.00
	0		0	1,132,939			
	C - LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	2,399	0		2.00
3.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	7,675	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,663	0		4.00
5.00	DIETARY	10.00	0	393	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,525	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	6,244	0		7.00
8.00	OPERATING ROOM	50.00	0	22,755	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,437	0		9.00
10.00	LABORATORY	60.00	0	1,044	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	20,950	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	393	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	393	0		13.00
14.00	CLINIC	90.00	0	956	0		14.00
15.00	WOUND CARE	90.02	0	393	0		15.00
16.00	EMERGENCY	91.00	0	1,679	0		16.00
17.00	AMBULANCE SERVICES	95.00	0	7,055	0		17.00
	0		0	79,347			
	D - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	19,162	10		1.00
2.00	AMBULANCE SERVICES	95.00	0	20,071	0		2.00
	0		0	39,233			
	E - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	1,230	0		1.00
2.00	WOUND CARE	90.02	0	1,228	0		2.00
3.00	ORTHOPEDIC CLINIC	90.03	0	1,379	0		3.00
	0		0	3,837			
	F - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	171,273	0		1.00
2.00	OPERATING ROOM	50.00	0	196,400	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	30,444	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	111	0		4.00
5.00	ORTHOPEDIC CLINIC	90.03	0	72	0		5.00
6.00	WOUND CARE	90.02	0	3,547	0		6.00
7.00	EMERGENCY	91.00	0	518	0		7.00
	0		0	402,365			
	G - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	116,970	0		1.00
	0		0	116,970			
	H - WOUND CARE RECLASS						
1.00	RURAL HEALTH CLINIC - TCC	88.00	13,724	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	85,907	0	0		2.00
	0		99,631	0			
	I - RHC RECRUITING EXPENSE RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	24,576	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	24,576			
	J - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,886	0		1.00
	0		0	16,886			
	L - TELL CITY RECLASS						
1.00	RURAL HEALTH CLINIC - TCC	88.00	220,050	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	69,044	0	0		2.00
	0		289,094	0			
	M - RHC CERTIFICAITON RECLASS						
1.00	RURAL HEALTH CLINIC III - 13TH	88.02	410,718	138,244	0		1.00
2.00	RURAL HEALTH CLINIC IV - SPENCER	88.03	133,480	62,696	0		2.00
	TOTALS		544,198	200,940			
500.00	Grand Total: Decreases		932,923	2,394,612			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I Date/Time Prepared: 6/24/2022 9:41 am

		Beginning Balances	Acquisitions Purchases	Donation	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	3,815,753	0	0	0	10,000	1.00
2.00	Land Improvements	59,357	212,920	0	212,920	0	2.00
3.00	Buildings and Fixtures	44,070,776	0	0	0	89,534	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,418,589	188,116	0	188,116	0	5.00
6.00	Movable Equipment	17,722,335	764,186	0	764,186	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,086,810	1,165,222	0	1,165,222	99,534	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,086,810	1,165,222	0	1,165,222	99,534	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,805,753	0	1.00
2.00	Land Improvements	272,277	0	2.00
3.00	Buildings and Fixtures	43,981,242	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,606,705	0	5.00
6.00	Movable Equipment	18,486,521	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,152,498	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	69,152,498	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 6/24/2022 9:41 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,449,648	0	0	95,000	9,340	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,449,648	0	0	95,000	9,340	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,553,988	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,553,988	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 6/24/2022 9:41 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	50,665,977	0	50,665,977	0.732670	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	18,486,521	0	18,486,521	0.267330	0	2.00
3.00	Total (sum of lines 1-2)	69,152,498	0	69,152,498	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,449,648	118,580	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	64,420	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,449,648	183,000	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	95,000	9,340	0	2,672,568	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,132,939	0	0	0	1,197,359	2.00
3.00	Total (sum of lines 1-2)	1,132,939	95,000	9,340	0	3,869,927	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 6/24/2022 9:41 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-929	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	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	-5,850	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,018	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,427,613			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	65,349			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-62,776	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-79,584	ADMINISTRATIVE AND GENERAL	5.01	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	B	-24	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,396	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	-13,269	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 6/24/2022 9:41 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		0		0.00	0	32.00
33.00	ADMINISTRATION MISCELLANEOUS REVENUE	B	-136,230	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	NONPATIENT SERVICES-CPR/EDU CLASSES-	B	-569	AMBULANCE SERVICES	95.00	0	33.01
33.02	ADMINISTRATION-MISC EXPENSES	A	-112,721	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	33.02
33.03	ADVERTISING - PCM	A	-70	RURAL HEALTH CLINIC II - PCFP	88.01	0	33.03
33.04	ADVERTISING - SPENCER	A	-38	RURAL HEALTH CLINIC IV - SPENCER	88.03	0	33.04
33.05	WOUND CENTER-ADVERTISING	A	-205	WOUND CARE	90.02	0	33.05
33.06	ADMINISTRATION-MISC EXPENSES	A	-8,863	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	HAF FEES	B	-840,997	ADMINISTRATIVE AND GENERAL	5.01	0	33.07
33.08	LOBBYING DUES	A	-4,996	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	CANNELTON OFFSET	A	-3,351	ADMINISTRATIVE AND GENERAL	5.01	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,638,150				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Date/Time Prepared: 6/24/2022 9:41 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65,349	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			65,349	0	5.00

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

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

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

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

6.00	B	PERRY CO AMBULA	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 6/24/2022 9:41 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	65,349	10	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	65,349		5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 6/24/2022 9:41 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	5.01	ADMINISTRATIVE AND GENERAL	685	685	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	926,036	97,000	829,036	0	0	2.00
3.00	50.00	OPERATING ROOM	682,677	682,677	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	123,564	123,564	0	0	0	4.00
5.00	60.00	LABORATORY	18,000	0	18,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	374,319	374,319	0	0	0	6.00
7.00	90.00	CLINIC	26,250	26,250	0	0	0	7.00
8.00	90.02	WOUND CARE	123,118	123,118	0	0	0	8.00
9.00	91.00	EMERGENCY	1,284,357	0	1,284,357	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,559,006	1,427,613	2,131,393		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	5.01	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.02	WOUND CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	5.01	ADMINISTRATIVE AND GENERAL	0	0	0	685	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	97,000	2.00
3.00	50.00	OPERATING ROOM	0	0	0	682,677	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	123,564	4.00
5.00	60.00	LABORATORY	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	374,319	6.00
7.00	90.00	CLINIC	0	0	0	26,250	7.00
8.00	90.02	WOUND CARE	0	0	0	123,118	8.00
9.00	91.00	EMERGENCY	0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,427,613	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,672,568	2,672,568				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,197,359		1,197,359			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	508,601	12,723	5,700	527,024		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	1,608,240	205,809	92,206	45,947	1,952,202	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	5,138,441	170,062	76,191	33,995	5,418,689	5.02
7.00	00700	OPERATION OF PLANT	1,940,215	515,935	231,147	8,238	2,695,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,329	4,402	1,972	0	82,703	8.00
9.00	00900	HOUSEKEEPING	450,274	29,606	13,264	8,525	501,669	9.00
10.00	01000	DIETARY	222,964	112,303	50,314	0	385,581	10.00
11.00	01100	CAFETERIA	314,743	0	0	0	314,743	11.00
13.00	01300	NURSING ADMINISTRATION	381,164	5,943	2,663	9,058	398,828	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	312,508	33,017	14,792	5,959	366,276	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,651,780	391,191	175,261	87,989	6,306,221	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,980	7,160	0	23,140	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	788,687	287,538	128,822	16,455	1,221,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,547	31,607	0	102,154	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,459,197	145,541	65,205	26,267	1,696,210	54.00
60.00	06000	LABORATORY	2,262,133	60,136	26,942	23,393	2,372,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	84,978	0	0	12	84,990	62.00
65.00	06500	RESPIRATORY THERAPY	1,018,557	90,424	40,512	14,840	1,164,333	65.00
66.00	06600	PHYSICAL THERAPY	609,056	44,464	19,920	15,552	688,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,291	19,304	8,649	5,046	233,290	67.00
68.00	06800	SPEECH PATHOLOGY	94,836	10,147	4,546	2,500	112,029	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	801,954	0	0	0	801,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	116,970	0	0	0	116,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,889,303	33,172	14,861	2,942	2,940,278	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	2,999,368	0	0	57,561	3,056,929	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,008,692	0	0	18,908	1,027,600	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,167,612	0	0	52,481	2,220,093	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	668,991	0	0	14,228	683,219	88.03
90.00	09000	CLINIC	544,776	98,942	44,328	9,159	697,205	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	275,604	34,822	15,601	9,825	335,852	90.02
90.03	09003	ORTHOPEDIC CLINIC	105,259	0	0	2,714	107,973	90.03
91.00	09100	EMERGENCY	2,331,803	150,934	67,621	21,615	2,571,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,106,790	99,052	44,377	20,582	1,270,801	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,010,043	2,641,994	1,183,661	513,791	41,952,538	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,574	13,698	0	44,272	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	736,040	0	0	13,233	749,273	192.00
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)	42,746,083	2,672,568	1,197,359	527,024	42,746,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	1,952,202					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	259,311	5,678,000	5,678,000			5.02
7.00	00700	OPERATION OF PLANT	128,995	2,824,530	442,016	3,266,546		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,958	86,661	13,562	8,134	108,357	8.00
9.00	00900	HOUSEKEEPING	24,007	525,676	82,264	54,698	18,534	9.00
10.00	01000	DIETARY	18,452	404,033	63,228	207,486	0	10.00
11.00	01100	CAFETERIA	15,062	329,805	51,612	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,086	417,914	65,400	10,980	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,528	383,804	60,062	61,001	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	301,795	6,608,016	1,034,109	722,745	33,723	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,107	24,247	3,794	29,525	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,455	1,279,957	200,303	531,241	8,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,889	107,043	16,751	130,340	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,172	1,777,382	278,146	268,894	11,798	54.00
60.00	06000	LABORATORY	113,541	2,486,145	389,062	111,104	307	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,067	89,057	13,937	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	55,719	1,220,052	190,928	167,063	2,526	65.00
66.00	06600	PHYSICAL THERAPY	32,972	721,964	112,982	82,149	2,332	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,164	244,454	38,255	35,666	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,361	117,390	18,371	18,748	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,378	840,332	131,505	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,598	122,568	19,181	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,707	3,080,985	482,150	61,286	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	146,289	3,203,218	501,278	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	49,176	1,076,776	168,507	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	106,243	2,326,336	364,053	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	32,695	715,914	112,035	0	0	88.03
90.00	09000	CLINIC	33,365	730,570	114,328	182,801	2,844	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	16,072	351,924	55,073	64,336	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	5,167	113,140	17,706	0	0	90.03
91.00	09100	EMERGENCY	123,082	2,695,055	421,755	278,858	27,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	60,814	1,331,615	208,387	183,004	216	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,914,227	41,914,563	5,670,740	3,210,059	108,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,119	46,391	7,260	56,487	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,856	785,129	0	0	0	192.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,952,202	42,746,083	5,678,000	3,266,546	108,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	681,172					9.00
10.00	01000	DIETARY	44,116	718,863				10.00
11.00	01100	CAFETERIA	0	0	381,417			11.00
13.00	01300	NURSING ADMINISTRATION	2,335	0	9,393	506,022		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,970	0	13,350	0	531,187	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153,669	718,863	122,961	321,302	156,329	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	6,278	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	112,952	0	22,502	58,830	10,086	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,713	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,172	0	40,504	0	16,810	54.00
60.00	06000	LABORATORY	23,623	0	46,484	0	40,343	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	35,521	0	24,163	0	26,896	65.00
66.00	06600	PHYSICAL THERAPY	17,466	0	21,143	0	6,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,583	0	6,766	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,986	0	2,658	0	6,724	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,031	0	6,252	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	38,867	0	13,622	35,583	141,202	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	13,679	0	11,659	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	5,407	0	0	90.03
91.00	09100	EMERGENCY	59,291	0	34,553	90,307	119,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	38,910	0	0	0	6,724	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	669,162	718,863	381,417	506,022	531,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,010	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	681,172	718,863	381,417	506,022	531,187	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,871,717	0	9,871,717		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	63,844	0	63,844		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,224,176	0	2,224,176		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,847	0	281,847		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,706	0	2,450,706		54.00
60.00	06000	LABORATORY	3,097,068	0	3,097,068		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,994	0	102,994		62.00
65.00	06500	RESPIRATORY THERAPY	1,667,149	0	1,667,149		65.00
66.00	06600	PHYSICAL THERAPY	964,760	0	964,760		66.00
67.00	06700	OCCUPATIONAL THERAPY	332,724	0	332,724		67.00
68.00	06800	SPEECH PATHOLOGY	167,877	0	167,877		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,837	0	971,837		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,749	0	141,749		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,643,704	0	3,643,704		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,704,496	0	3,704,496		88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,245,283	0	1,245,283		88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,690,389	0	2,690,389		88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	827,949	0	827,949		88.03
90.00	09000	CLINIC	1,259,817	0	1,259,817		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
90.02	09002	WOUND CARE	496,671	0	496,671		90.02
90.03	09003	ORTHOPEDIC CLINIC	136,253	0	136,253		90.03
91.00	09100	EMERGENCY	3,726,940	0	3,726,940		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,768,856	0	1,768,856		95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,838,806	0	41,838,806		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	122,148	0	122,148		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	785,129	0	785,129		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	42,746,083	0	42,746,083		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,723	5,700	18,423	18,423	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	205,809	92,206	298,015	1,607	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	0	170,062	76,191	246,253	1,189	5.02
7.00	00700	OPERATION OF PLANT	0	515,935	231,147	747,082	288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,402	1,972	6,374	0	8.00
9.00	00900	HOUSEKEEPING	0	29,606	13,264	42,870	298	9.00
10.00	01000	DIETARY	0	112,303	50,314	162,617	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,943	2,663	8,606	317	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,017	14,792	47,809	208	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	391,191	175,261	566,452	3,071	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,980	7,160	23,140	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	287,538	128,822	416,360	575	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,547	31,607	102,154	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,541	65,205	210,746	918	54.00
60.00	06000	LABORATORY	0	60,136	26,942	87,078	818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	90,424	40,512	130,936	519	65.00
66.00	06600	PHYSICAL THERAPY	0	44,464	19,920	64,384	544	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,304	8,649	27,953	176	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,147	4,546	14,693	87	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,172	14,861	48,033	103	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	2,013	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	661	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	1,835	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	498	88.03
90.00	09000	CLINIC	0	98,942	44,328	143,270	320	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	34,822	15,601	50,423	344	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	95	90.03
91.00	09100	EMERGENCY	0	150,934	67,621	218,555	756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	99,052	44,377	143,429	720	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,641,994	1,183,661	3,825,655	17,960	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,574	13,698	44,272	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	463	192.00
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	2,672,568	1,197,359	3,869,927	18,423	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	299,622					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	39,800	287,242				5.02
7.00	00700	OPERATION OF PLANT	19,799	22,362	789,531			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	607	686	1,966	9,633		8.00
9.00	00900	HOUSEKEEPING	3,685	4,162	13,221	1,648	65,884	9.00
10.00	01000	DIETARY	2,832	3,199	50,150	0	4,267	10.00
11.00	01100	CAFETERIA	2,312	2,611	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,929	3,309	2,654	0	226	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,690	3,039	14,744	0	1,254	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,311	52,305	174,691	2,998	14,864	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	170	192	7,136	0	607	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	10,133	128,402	738	10,925	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	750	847	31,503	0	2,680	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,459	14,072	64,992	1,049	5,530	54.00
60.00	06000	LABORATORY	17,427	19,683	26,854	27	2,285	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	624	705	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,552	9,659	40,379	225	3,436	65.00
66.00	06600	PHYSICAL THERAPY	5,061	5,716	19,855	207	1,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,714	1,935	8,620	0	733	67.00
68.00	06800	SPEECH PATHOLOGY	823	929	4,531	0	386	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,890	6,653	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	859	970	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,596	24,392	14,813	0	1,260	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	22,453	25,360	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	7,548	8,525	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	16,307	18,418	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	5,018	5,668	0	0	0	88.03
90.00	09000	CLINIC	5,121	5,784	44,183	253	3,759	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	2,467	2,786	15,550	0	1,323	90.02
90.03	09003	ORTHOPEDIC CLINIC	793	896	0	0	0	90.03
91.00	09100	EMERGENCY	18,891	21,337	67,401	2,469	5,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,334	10,542	44,233	19	3,763	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,794	286,875	775,878	9,633	64,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	325	367	13,653	0	1,162	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,503	0	0	0	0	192.00
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)	299,622	287,242	789,531	9,633	65,884	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	223,065					10.00
11.00	01100	CAFETERIA	0	4,923				11.00
13.00	01300	NURSING ADMINISTRATION	0	121	18,162			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	172	0	69,916		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	223,065	1,588	11,532	20,576	1,117,453	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	31,245	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	290	2,112	1,328	579,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	137,934	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	523	0	2,213	312,502	54.00
60.00	06000	LABORATORY	0	600	0	5,310	160,082	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,329	62.00
65.00	06500	RESPIRATORY THERAPY	0	312	0	3,540	197,558	65.00
66.00	06600	PHYSICAL THERAPY	0	273	0	885	98,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87	0	0	41,218	67.00
68.00	06800	SPEECH PATHOLOGY	0	34	0	885	22,368	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	12,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	81	0	0	110,278	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	49,826	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	16,734	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	36,560	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	11,184	88.03
90.00	09000	CLINIC	0	176	1,277	18,585	222,728	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	150	0	0	73,043	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	70	0	0	1,854	90.03
91.00	09100	EMERGENCY	0	446	3,241	15,709	354,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	885	212,925	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,065	4,923	18,162	69,916	3,804,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	59,779	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	5,966	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	223,065	4,923	18,162	69,916	3,869,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL			5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER			5.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,117,453	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	31,245	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	579,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	137,934	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	312,502	54.00
60.00	06000	LABORATORY	0	160,082	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,329	62.00
65.00	06500	RESPIRATORY THERAPY	0	197,558	65.00
66.00	06600	PHYSICAL THERAPY	0	98,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,218	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,368	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	110,278	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC	0	49,826	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	16,734	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	36,560	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	11,184	88.03
90.00	09000	CLINIC	0	222,728	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	0	73,043	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	1,854	90.03
91.00	09100	EMERGENCY	0	354,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	212,925	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,804,182	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,779	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,966	192.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,869,927	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	121,416					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		121,416				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578	578	16,891,512			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	9,350	9,350	1,472,627	-1,952,202	40,793,881	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	7,726	7,726	1,089,553	0	5,418,689	5.02
7.00	00700	OPERATION OF PLANT	23,439	23,439	264,016	0	2,695,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200	200	0	0	82,703	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	273,221	0	501,669	9.00
10.00	01000	DIETARY	5,102	5,102	0	0	385,581	10.00
11.00	01100	CAFETERIA	0	0	0	0	314,743	11.00
13.00	01300	NURSING ADMINISTRATION	270	270	290,304	0	398,828	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,500	191,003	0	366,276	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,772	17,772	2,820,350	0	6,306,221	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	726	726	0	0	23,140	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,063	13,063	527,401	0	1,221,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	3,205	0	0	102,154	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,612	6,612	841,856	0	1,696,210	54.00
60.00	06000	LABORATORY	2,732	2,732	749,752	0	2,372,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	384	0	84,990	62.00
65.00	06500	RESPIRATORY THERAPY	4,108	4,108	475,629	0	1,164,333	65.00
66.00	06600	PHYSICAL THERAPY	2,020	2,020	498,436	0	688,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	877	877	161,731	0	233,290	67.00
68.00	06800	SPEECH PATHOLOGY	461	461	80,115	0	112,029	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	801,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	116,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,507	1,507	94,281	0	2,940,278	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	1,844,836	0	3,056,929	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	606,018	0	1,027,600	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	1,682,044	0	2,220,093	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	456,012	0	683,219	88.03
90.00	09000	CLINIC	4,495	4,495	293,536	0	697,205	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	1,582	1,582	314,879	0	335,852	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	86,992	0	107,973	90.03
91.00	09100	EMERGENCY	6,857	6,857	692,751	0	2,571,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,500	4,500	659,657	0	1,270,801	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,027	120,027	16,467,384	-1,952,202	40,000,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,389	1,389	0	0	44,272	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	424,128	0	749,273	192.00
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)	2,672,568	1,197,359	527,024		1,952,202	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.011662	9.861624	0.031201		0.047855	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,423		299,622	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001091		0.007345	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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-5,678,000	36,282,954				5.02
7.00	00700	OPERATION OF PLANT	0	2,824,530	80,323			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,661	200	9,524		8.00
9.00	00900	HOUSEKEEPING	0	525,676	1,345	1,629	78,778	9.00
10.00	01000	DIETARY	0	404,033	5,102	0	5,102	10.00
11.00	01100	CAFETERIA	0	329,805	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	417,914	270	0	270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	383,804	1,500	0	1,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,608,016	17,772	2,964	17,772	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	24,247	726	0	726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,279,957	13,063	730	13,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	107,043	3,205	0	3,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,777,382	6,612	1,037	6,612	54.00
60.00	06000	LABORATORY	0	2,486,145	2,732	27	2,732	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	89,057	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,220,052	4,108	222	4,108	65.00
66.00	06600	PHYSICAL THERAPY	0	721,964	2,020	205	2,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	244,454	877	0	877	67.00
68.00	06800	SPEECH PATHOLOGY	0	117,390	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	840,332	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	122,568	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,080,985	1,507	0	1,507	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	3,203,218	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	1,076,776	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	2,326,336	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	715,914	0	0	0	88.03
90.00	09000	CLINIC	0	730,570	4,495	250	4,495	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	351,924	1,582	0	1,582	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	113,140	0	0	0	90.03
91.00	09100	EMERGENCY	0	2,695,055	6,857	2,441	6,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,331,615	4,500	19	4,500	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,678,000	36,236,563	78,934	9,524	77,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,391	1,389	0	1,389	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-785,129	0	0	0	0	192.00
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)		5,678,000	3,266,546	108,357	681,172	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.156492	40.667629	11.377257	8.646729	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		287,242	789,531	9,633	65,884	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007917	9.829451	1.011445	0.836325	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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 6/24/2022 9:41 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	9,243					10.00
11.00	01100	CAFETERIA	0	12,628				11.00
13.00	01300	NURSING ADMINISTRATION	0	311	133,365			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	442	0	316		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,243	4,071	84,681	93		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	745	15,505	6		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,341	0	10		54.00
60.00	06000	LABORATORY	0	1,539	0	24		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	800	0	16		65.00
66.00	06600	PHYSICAL THERAPY	0	700	0	4		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	224	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	88	0	4		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	207	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0		88.03
90.00	09000	CLINIC	0	451	9,378	84		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
90.02	09002	WOUND CARE	0	386	0	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	179	0	0		90.03
91.00	09100	EMERGENCY	0	1,144	23,801	71		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	4		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,243	12,628	133,365	316		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
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)	718,863	381,417	506,022	531,187		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	77.773775	30.204070	3.794264	1,680.971519		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	223,065	4,923	18,162	69,916		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.133398	0.389848	0.136183	221.253165		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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	9,871,717		9,871,717	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	63,844		63,844	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,224,176		2,224,176	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,847		281,847	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,706		2,450,706	0	0	54.00
60.00	06000	LABORATORY	3,097,068		3,097,068	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,994		102,994	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,667,149	0	1,667,149	0	0	65.00
66.00	06600	PHYSICAL THERAPY	964,760	0	964,760	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,724	0	332,724	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	167,877	0	167,877	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,837		971,837	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,749		141,749	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,643,704		3,643,704	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,704,496		3,704,496	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,245,283		1,245,283	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,690,389		2,690,389	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	827,949		827,949	0	0	88.03
90.00	09000	CLINIC	1,259,817		1,259,817	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	496,671		496,671	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	136,253		136,253	0	0	90.03
91.00	09100	EMERGENCY	3,726,940		3,726,940	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,293,170		1,293,170		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,768,856		1,768,856	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	43,131,976	0	43,131,976	0	0	200.00
201.00		Less Observation Beds	1,293,170		1,293,170		0	201.00
202.00		Total (see instructions)	41,838,806	0	41,838,806	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	5,886,773		5,886,773			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	118,941		118,941			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,375,247	9,011,040	10,386,287	0.214145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	469,607	218,410	688,017	0.409651	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,317	18,141,421	19,350,738	0.126647	0.000000	54.00
60.00	06000	LABORATORY	1,880,132	19,368,751	21,248,883	0.145752	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	51,358	314,220	365,578	0.281729	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,184,966	3,050,388	4,235,354	0.393627	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	609,701	2,322,358	2,932,059	0.329038	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,251	722,774	1,236,025	0.269189	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	97,265	350,499	447,764	0.374923	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,022,233	3,323,368	5,345,601	0.181801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	150,891	150,891	0.939413	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,292,563	12,602,423	16,894,986	0.215668	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	4,378,254	4,378,254			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	1,842,063	1,842,063			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	1,614,104	1,614,104			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	913,674	913,674			88.03
90.00	09000	CLINIC	38,132	918,965	957,097	1.316290	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	15,573	1,458,674	1,474,247	0.336898	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	648,363	648,363	0.210149	0.000000	90.03
91.00	09100	EMERGENCY	456,596	8,041,946	8,498,542	0.438539	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,224	673,484	714,708	1.809368	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,649,416	4,649,416	0.380447	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	20,262,879	94,715,486	114,978,365			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,262,879	94,715,486	114,978,365			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - TCC		88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP		88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH		88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER		88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	9,871,717		9,871,717	0	9,871,717	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	63,844		63,844	0	63,844	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,224,176		2,224,176	0	2,224,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,847		281,847	0	281,847	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,706		2,450,706	0	2,450,706	54.00
60.00	06000	LABORATORY	3,097,068		3,097,068	0	3,097,068	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,994		102,994	0	102,994	62.00
65.00	06500	RESPIRATORY THERAPY	1,667,149	0	1,667,149	0	1,667,149	65.00
66.00	06600	PHYSICAL THERAPY	964,760	0	964,760	0	964,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,724	0	332,724	0	332,724	67.00
68.00	06800	SPEECH PATHOLOGY	167,877	0	167,877	0	167,877	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,837		971,837	0	971,837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,749		141,749	0	141,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,643,704		3,643,704	0	3,643,704	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,704,496		3,704,496	0	3,704,496	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,245,283		1,245,283	0	1,245,283	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,690,389		2,690,389	0	2,690,389	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	827,949		827,949	0	827,949	88.03
90.00	09000	CLINIC	1,259,817		1,259,817	0	1,259,817	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	496,671		496,671	0	496,671	90.02
90.03	09003	ORTHOPEDIC CLINIC	136,253		136,253	0	136,253	90.03
91.00	09100	EMERGENCY	3,726,940		3,726,940	0	3,726,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,293,170		1,293,170		1,293,170	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,768,856		1,768,856	0	1,768,856	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	43,131,976	0	43,131,976	0	43,131,976	200.00
201.00		Less Observation Beds	1,293,170		1,293,170		1,293,170	201.00
202.00		Total (see instructions)	41,838,806	0	41,838,806	0	41,838,806	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	5,886,773		5,886,773			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	118,941		118,941			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,375,247	9,011,040	10,386,287	0.214145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	469,607	218,410	688,017	0.409651	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,317	18,141,421	19,350,738	0.126647	0.000000	54.00
60.00	06000	LABORATORY	1,880,132	19,368,751	21,248,883	0.145752	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	51,358	314,220	365,578	0.281729	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,184,966	3,050,388	4,235,354	0.393627	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	609,701	2,322,358	2,932,059	0.329038	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,251	722,774	1,236,025	0.269189	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	97,265	350,499	447,764	0.374923	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,022,233	3,323,368	5,345,601	0.181801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	150,891	150,891	0.939413	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,292,563	12,602,423	16,894,986	0.215668	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	4,378,254	4,378,254	0.846113	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	1,842,063	1,842,063	0.676026	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	1,614,104	1,614,104	1.666800	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	913,674	913,674	0.906176	0.000000	88.03
90.00	09000	CLINIC	38,132	918,965	957,097	1.316290	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	15,573	1,458,674	1,474,247	0.336898	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	648,363	648,363	0.210149	0.000000	90.03
91.00	09100	EMERGENCY	456,596	8,041,946	8,498,542	0.438539	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,224	673,484	714,708	1.809368	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,649,416	4,649,416	0.380447	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	20,262,879	94,715,486	114,978,365			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	20,262,879	94,715,486	114,978,365			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	0.214145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	54.00
60.00	06000	LABORATORY	0.145752	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - TCC	0.846113	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.676026	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	1.666800	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.906176	88.03
90.00	09000	CLINIC	1.316290	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.336898	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	90.03
91.00	09100	EMERGENCY	0.438539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.380447	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,224,176	579,835	1,644,341	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,847	137,934	143,913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,706	312,502	2,138,204	0	0	54.00
60.00	06000	LABORATORY	3,097,068	160,082	2,936,986	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,994	1,329	101,665	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,667,149	197,558	1,469,591	0	0	65.00
66.00	06600	PHYSICAL THERAPY	964,760	98,614	866,146	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,724	41,218	291,506	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	167,877	22,368	145,509	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,837	12,543	959,294	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,749	1,829	139,920	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,643,704	110,278	3,533,426	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,704,496	49,826	3,654,670	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,245,283	16,734	1,228,549	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,690,389	36,560	2,653,829	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	827,949	11,184	816,765	0	0	88.03
90.00	09000	CLINIC	1,259,817	222,728	1,037,089	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	496,671	73,043	423,628	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	136,253	1,854	134,399	0	0	90.03
91.00	09100	EMERGENCY	3,726,940	354,540	3,372,400	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,293,170	146,383	1,146,787	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,768,856	212,925	1,555,931	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	33,196,415	2,801,867	30,394,548	0	0	200.00
201.00		Less Observation Beds	1,293,170	146,383	1,146,787	0	0	201.00
202.00		Total (line 200 minus line 201)	31,903,245	2,655,484	29,247,761	0	0	202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,224,176	10,386,287	0.214145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,847	688,017	0.409651	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,706	19,350,738	0.126647	54.00
60.00	06000	LABORATORY	3,097,068	21,248,883	0.145752	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,994	365,578	0.281729	62.00
65.00	06500	RESPIRATORY THERAPY	1,667,149	4,235,354	0.393627	65.00
66.00	06600	PHYSICAL THERAPY	964,760	2,932,059	0.329038	66.00
67.00	06700	OCCUPATIONAL THERAPY	332,724	1,236,025	0.269189	67.00
68.00	06800	SPEECH PATHOLOGY	167,877	447,764	0.374923	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,837	5,345,601	0.181801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,749	150,891	0.939413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,643,704	16,894,986	0.215668	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	3,704,496	4,378,254	0.846113	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,245,283	1,842,063	0.676026	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,690,389	1,614,104	1.666800	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	827,949	913,674	0.906176	88.03
90.00	09000	CLINIC	1,259,817	957,097	1.316290	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	90.01
90.02	09002	WOUND CARE	496,671	1,474,247	0.336898	90.02
90.03	09003	ORTHOPEDIC CLINIC	136,253	648,363	0.210149	90.03
91.00	09100	EMERGENCY	3,726,940	8,498,542	0.438539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,293,170	714,708	1.809368	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,768,856	4,649,416	0.380447	95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	33,196,415	108,972,651		200.00
201.00		Less Observation Beds	1,293,170	0		201.00
202.00		Total (line 200 minus line 201)	31,903,245	108,972,651		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 6/24/2022 9:41 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	579,835	10,386,287	0.055827	219,543	12,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,934	688,017	0.200481	5,499	1,102	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,502	19,350,738	0.016149	456,549	7,373	54.00
60.00	06000	LABORATORY	160,082	21,248,883	0.007534	570,546	4,298	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,329	365,578	0.003635	18,345	67	62.00
65.00	06500	RESPIRATORY THERAPY	197,558	4,235,354	0.046645	395,108	18,430	65.00
66.00	06600	PHYSICAL THERAPY	98,614	2,932,059	0.033633	147,771	4,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,218	1,236,025	0.033347	107,587	3,588	67.00
68.00	06800	SPEECH PATHOLOGY	22,368	447,764	0.049955	20,520	1,025	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,543	5,345,601	0.002346	596,789	1,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,829	150,891	0.012121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,278	16,894,986	0.006527	1,404,220	9,165	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	49,826	4,378,254	0.011380	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	16,734	1,842,063	0.009084	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	36,560	1,614,104	0.022650	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	11,184	913,674	0.012241	0	0	88.03
90.00	09000	CLINIC	222,728	957,097	0.232712	12,354	2,875	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	73,043	1,474,247	0.049546	3,386	168	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,854	648,363	0.002860	0	0	90.03
91.00	09100	EMERGENCY	354,540	8,498,542	0.041718	22,610	943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,383	714,708	0.204815	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,588,942	104,323,235		3,980,827	67,660	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 6/24/2022 9:41 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 6/24/2022 9:41 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	10,386,287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	688,017	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,350,738	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	21,248,883	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	365,578	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,235,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,932,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,236,025	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	447,764	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,345,601	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	150,891	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,894,986	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	4,378,254	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	1,842,063	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	1,614,104	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	913,674	0.000000	88.03
90.00	09000	CLINIC	0	0	0	957,097	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,474,247	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	648,363	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	8,498,542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	714,708	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	104,323,235		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 6/24/2022 9:41 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	219,543	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,499	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	456,549	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	570,546	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	18,345	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	395,108	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	147,771	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	107,587	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	20,520	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	596,789	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,404,220	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	12,354	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	3,386	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	22,610	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,980,827	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 6/24/2022 9:41 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	0.214145	0	1,703,897	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	0	4,808,782	0	0	54.00
60.00	06000	LABORATORY	0.145752	0	2,858,443	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	0	113,115	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	0	746,240	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	0	625,028	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	0	171,453	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	0	38,992	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	0	614,210	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	0	81,318	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	0	5,547,536	1,702	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC						88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP						88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH						88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER						88.03
90.00	09000	CLINIC	1.316290	0	138,655	23,916	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.336898	0	576,298	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.438539	0	1,974,839	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	0	210,691	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.380447		0			95.00
200.00		Subtotal (see instructions)		0	20,209,497	25,618	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	20,209,497	25,618	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 6/24/2022 9:41 am
	Title XVIII	Hospital	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	364,881	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,018	0	54.00
60.00	06000	LABORATORY	416,624	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,868	0	62.00
65.00	06500	RESPIRATORY THERAPY	293,740	0	65.00
66.00	06600	PHYSICAL THERAPY	205,658	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,153	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,619	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	111,664	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	76,391	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,196,426	367	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER			88.03
90.00	09000	CLINIC	182,510	31,480	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	194,154	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	866,044	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	381,218	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,990,968	31,847	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,990,968	31,847	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,117,453	267,791	849,662	2,670	318.23	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	31,245		31,245	122	256.11	43.00
200.00	Total (lines 30 through 199)	1,148,698		880,907	2,792		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	33	10,502	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	33	10,502	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	579,835	10,386,287	0.055827	450,117	25,129	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,934	688,017	0.200481	184,593	37,007	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,502	19,350,738	0.016149	96,150	1,553	54.00
60.00	06000	LABORATORY	160,082	21,248,883	0.007534	188,004	1,416	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,329	365,578	0.003635	8,273	30	62.00
65.00	06500	RESPIRATORY THERAPY	197,558	4,235,354	0.046645	61,903	2,887	65.00
66.00	06600	PHYSICAL THERAPY	98,614	2,932,059	0.033633	5,577	188	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,218	1,236,025	0.033347	3,652	122	67.00
68.00	06800	SPEECH PATHOLOGY	22,368	447,764	0.049955	1,877	94	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,543	5,345,601	0.002346	268,821	631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,829	150,891	0.012121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,278	16,894,986	0.006527	481,714	3,144	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	49,826	4,378,254	0.011380	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	16,734	1,842,063	0.009084	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	36,560	1,614,104	0.022650	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	11,184	913,674	0.012241	0	0	88.03
90.00	09000	CLINIC	222,728	957,097	0.232712	18,081	4,208	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	73,043	1,474,247	0.049546	8,628	427	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,854	648,363	0.002860	0	0	90.03
91.00	09100	EMERGENCY	354,540	8,498,542	0.041718	89,768	3,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,383	714,708	0.204815	6,819	1,397	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,588,942	104,323,235		1,873,977	81,978	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,670	0.00	33	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	122	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,792		33	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 6/24/2022 9:41 am
	Title XIX	Hospital	PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,386,287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	688,017	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,350,738	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	21,248,883	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	365,578	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,235,354	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,932,059	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,236,025	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	447,764	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,345,601	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	150,891	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,894,986	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	4,378,254	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	1,842,063	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	1,614,104	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	913,674	0.000000	88.03
90.00	09000	CLINIC	0	0	0	957,097	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,474,247	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	648,363	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	8,498,542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	714,708	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	104,323,235		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	450,117	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	184,593	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	96,150	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	188,004	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	8,273	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	61,903	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,577	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,652	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,877	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	268,821	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	481,714	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	18,081	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	8,628	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	89,768	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,819	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,873,977	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	0.214145	0	1,442,767	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	0	41,875	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	0	2,118,148	0	0	54.00
60.00	06000	LABORATORY	0.145752	0	2,368,433	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	0	10,577	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	0	361,501	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	0	255,457	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	0	112,218	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	0	74,751	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	0	496,850	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	0	4,042	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	0	1,289,322	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC						88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP						88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH						88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER						88.03
90.00	09000	CLINIC	1.316290	0	90,715	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.336898	0	148,562	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.438539	0	1,233,997	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	0	75,991	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.380447	0	88,799			95.00
200.00		Subtotal (see instructions)		0	10,214,005	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	10,214,005	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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	308,961	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,154	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	268,257	0	54.00
60.00	06000	LABORATORY	345,204	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,980	0	62.00
65.00	06500	RESPIRATORY THERAPY	142,297	0	65.00
66.00	06600	PHYSICAL THERAPY	84,055	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,208	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,026	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,328	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,797	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	278,065	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER			88.03
90.00	09000	CLINIC	119,407	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	50,050	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	541,156	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	137,496	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	33,783		95.00
200.00		Subtotal (see instructions)	2,481,224	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,481,224	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 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)	3,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,670	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,210	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	213	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)	959	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)	824	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,871,717	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)	49,224	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,365,694	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,506,023	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)	7,506,023	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)	2,811.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,695,989	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)	2,695,989	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	874,874	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,570,863	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)	2,316,470	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)	2,316,470	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)	460	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,811.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,293,170	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 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	1,117,453	9,871,717	0.113197	1,293,170	146,383	90.00
91.00	Nursing Program cost	0	9,871,717	0.000000	1,293,170	0	91.00
92.00	Allied health cost	0	9,871,717	0.000000	1,293,170	0	92.00
93.00	All other Medical Education	0	9,871,717	0.000000	1,293,170	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,670	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,210	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	213	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)	122	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,871,717	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)	49,224	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,365,694	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,506,023	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)	7,506,023	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)	2,811.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,771	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)	92,771	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	63,844	122	523.31	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	472,982	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	565,753	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)	10,502	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	81,978	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	92,480	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	473,273	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)	460	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,811.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,293,170	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,117,453	9,871,717	0.113197	1,293,170	146,383	90.00
91.00	Nursing Program cost	0	9,871,717	0.000000	1,293,170	0	91.00
92.00	Allied health cost	0	9,871,717	0.000000	1,293,170	0	92.00
93.00	All other Medical Education	0	9,871,717	0.000000	1,293,170	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 6/24/2022 9:41 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		1,650,554		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214145	219,543	47,014	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	5,499	2,253	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	456,549	57,821	54.00
60.00	06000	LABORATORY	0.145752	570,546	83,158	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	18,345	5,168	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	395,108	155,525	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	147,771	48,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	107,587	28,961	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	20,520	7,693	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	596,789	108,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	1,404,220	302,845	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000		0	88.03
90.00	09000	CLINIC	1.316290	12,354	16,261	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.336898	3,386	1,141	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	0	0	90.03
91.00	09100	EMERGENCY	0.438539	22,610	9,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,980,827	874,874	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)		3,980,827		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 6/24/2022 9:41 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	0.214145	236	51	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	3,518	446	54.00
60.00	06000	LABORATORY	0.145752	141,093	20,565	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	99,450	39,146	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	292,446	96,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	276,723	74,491	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	45,117	16,915	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	189,921	34,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	339,850	73,295	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000		0	88.03
90.00	09000	CLINIC	1.316290	845	1,112	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.336898	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	0	0	90.03
91.00	09100	EMERGENCY	0.438539	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,389,199	356,775	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)		1,389,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 6/24/2022 9:41 am

Title XIX | Hospital | PPS

		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		313,425		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		1,934		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214145	450,117	96,390	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.409651	184,593	75,619	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126647	96,150	12,177	54.00
60.00	06000	LABORATORY	0.145752	188,004	27,402	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281729	8,273	2,331	62.00
65.00	06500	RESPIRATORY THERAPY	0.393627	61,903	24,367	65.00
66.00	06600	PHYSICAL THERAPY	0.329038	5,577	1,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.269189	3,652	983	67.00
68.00	06800	SPEECH PATHOLOGY	0.374923	1,877	704	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181801	268,821	48,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.939413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215668	481,714	103,890	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.846113	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.676026	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	1.666800	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.906176	0	0	88.03
90.00	09000	CLINIC	1.316290	18,081	23,800	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.336898	8,628	2,907	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.210149	0	0	90.03
91.00	09100	EMERGENCY	0.438539	89,768	39,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	6,819	12,338	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,873,977	472,982	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)		1,873,977		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part B Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,022,815	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,022,815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,073,043	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	31,579	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,429,604	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)	1,611,860	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)	1,611,860	30.00
31.00	Primary payer payments	1,016	31.00
32.00	Subtotal (line 30 minus line 31)	1,610,844	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)	352,828	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	229,338	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	223,981	36.00
37.00	Subtotal (see instructions)	1,840,182	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)	1,840,182	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	2,386,562	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)	-546,380	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	123,490	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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 6/24/2022 9:41 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		3,061,705		2,241,662	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	10/28/2021	27,500	10/28/2021	144,900	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)		27,500		144,900	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)		3,089,205		2,386,562	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		246,559		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		546,380	6.02
7.00	Total Medicare program liability (see instructions)		3,335,764		1,840,182	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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 6/24/2022 9:41 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		2,437,439		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	10/28/2021	92,500		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)		92,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,529,939		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		166,885		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,696,824		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: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 6/24/2022 9:41 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: 15-1322 Component CCN: 15-Z322	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2 Date/Time Prepared: 6/24/2022 9:41 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)	2,339,635	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)	360,343	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	824	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,699,978	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,699,978	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,699,978	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,154	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,696,824	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,696,824	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,529,939	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)	166,885	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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part V Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,570,863	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,570,863	4.00
5.00	Primary payer payments	3,682	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,602,890	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,602,890	19.00
20.00	Deductibles (exclude professional component)	287,820	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,315,070	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,315,070	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,837	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,694	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,653	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,335,764	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)	3,335,764	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	3,089,205	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)	246,559	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	11,143	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G Date/Time Prepared: 6/24/2022 9:41 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	14,978,154	0	0	0	1.00
2.00	Temporary investments	3,920,204	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,502,881	0	0	0	4.00
5.00	Other receivable	1,209,934	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,986,858	0	0	0	6.00
7.00	Inventory	730,398	0	0	0	7.00
8.00	Prepaid expenses	449,574	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,820,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,624,287	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,805,753	0	0	0	12.00
13.00	Land improvements	272,277	0	0	0	13.00
14.00	Accumulated depreciation	-13,551,924	0	0	0	14.00
15.00	Buildings	43,981,242	0	0	0	15.00
16.00	Accumulated depreciation	-2,713,126	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	2,606,705	0	0	0	19.00
20.00	Accumulated depreciation	-167,416	0	0	0	20.00
21.00	Automobiles and trucks	477,834	0	0	0	21.00
22.00	Accumulated depreciation	-445,159	0	0	0	22.00
23.00	Major movable equipment	18,008,687	0	0	0	23.00
24.00	Accumulated depreciation	-9,880,174	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)	42,394,699	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,018,986	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,414,572	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	671,530	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,394,187	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,338,726	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,819,015	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	35,376,000	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)	35,376,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,195,015	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,823,971				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)	28,823,971	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,018,986	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 6/24/2022 9:41 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		26,612,118		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,624,479				2.00
3.00	Total (sum of line 1 and line 2)		29,236,597		0		3.00
4.00	FREE STANDING HOME HEALTH	-412,626		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)		-412,626		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,823,971		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)		28,823,971		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	FREE STANDING HOME HEALTH		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: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/24/2022 9:41 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,105,597		6,105,597	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)	6,105,597		6,105,597	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,105,597		6,105,597	17.00
18.00	Ancillary services	14,132,853	81,487,408	95,620,261	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC - TCC	0	4,378,254	4,378,254	20.00
20.01	RURAL HEALTH CLINIC II - PCFP	0	1,842,063	1,842,063	20.01
20.02	RURAL HEALTH CLINIC III - 13TH	0	2,089,185	2,089,185	20.02
20.03	RURAL HEALTH CLINIC IV - SPENCER	0	1,182,597	1,182,597	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,649,416	4,649,416	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	20,238,450	95,628,923	115,867,373	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,384,233		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,384,233		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 6/24/2022 9:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,867,373	1.00
2.00	Less contractual allowances and discounts on patients' accounts	73,988,861	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,878,512	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,384,233	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,505,721	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	445,895	6.00
7.00	Income from investments	93,375	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	92,597	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	62,776	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	79,584	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	3,288,158	24.00
24.50	COVID-19 PHE Funding	2,067,815	24.50
25.00	Total other income (sum of lines 6-24)	6,130,200	25.00
26.00	Total (line 5 plus line 25)	2,624,479	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)	2,624,479	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,272,673	0	1,272,673	-225,073	1,047,600	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	225,105	0	225,105	0	225,105	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	197,903	0	197,903	0	197,903	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	182,293	44,000	226,293	0	226,293	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,877,974	44,000	1,921,974	-225,073	1,696,901	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,854	23,854	0	23,854	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	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	23,854	23,854	0	23,854	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,877,974	67,854	1,945,828	-225,073	1,720,755	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	36,632	36,632	0	36,632	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	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	36,632	36,632	0	36,632	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	200,636	1,041,345	1,241,981	0	1,241,981	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	200,636	1,041,345	1,241,981	0	1,241,981	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,078,610	1,145,831	3,224,441	-225,073	2,999,368	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,047,600	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	225,105	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	197,903	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	226,293	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,696,901	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	23,854	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,854	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,720,755	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	36,632	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	36,632	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	1,241,981	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,241,981	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,999,368	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	425,958	0	425,958	0	425,958	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	34,965	0	34,965	0	34,965	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	92,421	0	92,421	0	92,421	9.00
10.00	Subtotal (sum of lines 1 through 9)	553,344	0	553,344	0	553,344	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	8,916	8,916	0	8,916	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	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	8,916	8,916	0	8,916	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	553,344	8,916	562,260	0	562,260	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	97,049	97,049	0	97,049	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	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	97,049	97,049	0	97,049	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	52,674	296,779	349,453	0	349,453	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,674	296,779	349,453	0	349,453	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	606,018	402,744	1,008,762	0	1,008,762	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	425,958	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	34,965	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	92,421	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	553,344	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	8,916	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,916	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	562,260	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	97,049	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	97,049	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-70	349,383	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-70	349,383	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-70	1,008,692	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,564,088	0	1,564,088	-339,796	1,224,292	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	286,593	286,593	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	122,060	0	122,060	-27,756	94,304	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	89,013	0	89,013	-20,241	68,772	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,775,161	0	1,775,161	-101,200	1,673,961	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	14,170	14,170	-3,222	10,948	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	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	14,170	14,170	-3,222	10,948	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,775,161	14,170	1,789,331	-104,422	1,684,909	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	17,478	17,478	-3,974	13,504	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	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	17,478	17,478	-3,974	13,504	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	31,008	576,289	607,297	-138,098	469,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	31,008	576,289	607,297	-138,098	469,199	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,806,169	607,937	2,414,106	-246,494	2,167,612	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,224,292	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	286,593	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	94,304	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	68,772	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,673,961	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	10,948	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,948	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,684,909	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	13,504	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,504	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	469,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	469,199	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,167,612	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	393,071	0	393,071	-86,881	306,190	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	115,904	0	115,904	-26,357	89,547	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	25,422	0	25,422	-5,781	19,641	9.00
10.00	Subtotal (sum of lines 1 through 9)	534,397	0	534,397	-119,019	415,378	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	194	194	-44	150	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	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	194	194	-44	150	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	534,397	194	534,591	-119,063	415,528	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	15,624	15,624	-3,553	12,071	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	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	15,624	15,624	-3,553	12,071	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	52,595	259,895	312,490	-71,060	241,430	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,595	259,895	312,490	-71,060	241,430	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	586,992	275,713	862,705	-193,676	669,029	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 6/24/2022 9:41 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	306,190	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	89,547	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	19,641	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	415,378	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	150	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	150	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	415,528	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	12,071	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	12,071	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-38	241,392	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-38	241,392	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-38	668,991	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 6/24/2022 9:41 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.17	7,532	4,200	9,114		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.17	7,268	2,100	6,657		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.34	14,800		15,771	15,771	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.34	14,800			15,771	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)	1,720,755	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	36,632	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,757,387	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.979155	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	1,241,981	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	705,128	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,947,109	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,947,109	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,906,522	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,627,277	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 6/24/2022 9:41 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.72	1,986	4,200	3,024		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.72	1,986		3,024	3,024	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.72	1,986			3,024	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)	562,260	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	97,049	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	659,309	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.852802	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	349,383	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	236,591	15.00
16.00	Total overhead (sum of lines 14 and 15)	585,974	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	585,974	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	499,720	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,061,980	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.49	3,658	3,245	4,835		1.00
2.00	Physician Assistant	0.00	0	1,622	0		2.00
3.00	Nurse Practitioner	0.49	499	1,622	795		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.98	4,157		5,630	5,630	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.98	4,157			5,630	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)	1,684,909	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	13,504	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,698,413	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.992049	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	469,199	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	522,777	15.00
16.00	Total overhead (sum of lines 14 and 15)	991,976	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	991,976	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	984,089	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,668,998	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8562	Period: From 01/01/2021 To 12/31/2021	Worksheet M-2 Date/Time Prepared: 6/24/2022 9:41 am
		RHC IV	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.91	4,009	3,245	2,953		1.00
2.00	Physician Assistant	0.00	0	1,622	0		2.00
3.00	Nurse Practitioner	0.00	0	1,622	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.91	4,009		2,953	4,009	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.91	4,009			4,009	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)	415,528	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	12,071	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	427,599	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.971770	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	241,392	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	158,958	15.00
16.00	Total overhead (sum of lines 14 and 15)	400,350	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	400,350	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	389,048	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	804,576	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 6/24/2022 9:41 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,627,277	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		84,143	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,543,134	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,771	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)		15,771	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		224.66	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	220.95	8.00
9.00	Rate for Program covered visits (see instructions)	224.66	220.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	600	1,801	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	134,796	397,931	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	532,727	16.00
16.01	Total program charges (see instructions)(from contractor's records)		565,503	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		124,649	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		117,424	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.)		293,109	16.04
16.05	Total program cost (see instructions)	0	410,533	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		48,917	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		78,388	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		410,533	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		32,671	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		443,204	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)		443,204	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		407,829	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)		35,375	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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 6/24/2022 9:41 am
	Title XVIII	RHC II	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,061,980	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	329,879	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	732,101	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	3,024	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)	3,024	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	242.10	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	159.42	8.00
9.00	Rate for Program covered visits (see instructions)	242.10	159.42	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	42	127	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	10,168	20,246	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	30,414	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,867	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,446	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,629	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.)		15,390	16.04
16.05	Total program cost (see instructions)	0	24,019	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,547	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,775	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		24,019	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,820	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		34,839	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)		34,839	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		23,334	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)		11,505	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: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-3 | Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | RHC III | Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,668,998	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		16,444	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,652,554	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,630	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)		5,630	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		471.15	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	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	471.15	100.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	28	83	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	13,192	8,300	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	21,492	16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,675	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		727	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		660	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.)		10,821	16.04
16.05	Total program cost (see instructions)	0	11,481	16.05
17.00	Primary payer amounts		8	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,306	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,129	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		11,473	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,416	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		12,889	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)		12,889	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		3,697	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)		9,192	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: 15-1322 Component CCN: 15-8562	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 6/24/2022 9:41 am
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		804,576	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		70,614	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		733,962	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,009	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,009	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		183.08	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	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	183.08	100.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	68	203	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	12,449	20,300	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	32,749	16.00
16.01	Total program charges (see instructions)(from contractor's records)		64,229	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		727	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		371	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.)		4,190	16.04
16.05	Total program cost (see instructions)	0	4,561	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,141	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,273	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		4,561	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,449	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		27,010	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)		27,010	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		591	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)		26,419	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: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,696,901	1,696,901	1,696,901	1,696,901	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001110	0.005177	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,884	8,785	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	15,408	13,840	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,292	22,625	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,720,755	1,720,755	1,720,755	1,720,755	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,906,522	1,906,522	1,906,522	1,906,522	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010049	0.013148	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	19,159	25,067	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	36,451	47,692	0	0	10.00
11.00	Total number of injections/infusions (from your records)	74	345	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	492.58	138.24	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	29	133	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)	14,285	18,386	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)		84,143			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)		32,671			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4

Component CCN: 15-8517 | Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	553,344	553,344	553,344	553,344	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.042279	0.069537	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	23,395	38,478	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	87,780	25,000	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	111,175	63,478	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	562,260	562,260	562,260	562,260	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	499,720	499,720	499,720	499,720	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.197729	0.112898	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	98,809	56,417	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	209,984	119,895	0	0	10.00
11.00	Total number of injections/infusions (from your records)	380	625	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	552.59	191.83	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	42	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)	2,763	8,057	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)		329,879			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)		10,820			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1322 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4
Component CCN: 15-8560 | Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,673,961	1,673,961	1,673,961	1,673,961	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002590	0.003521	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,336	5,894	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	64	87	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,400	5,981	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,684,909	1,684,909	1,684,909	1,684,909	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	984,089	984,089	984,089	984,089	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002611	0.003550	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,569	3,494	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,969	9,475	0	0	10.00
11.00	Total number of injections/infusions (from your records)	64	87	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	108.89	108.91	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	12	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)	109	1,307	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)		16,444			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)		1,416			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 6/24/2022 9:41 am

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	415,378	415,378	415,378	415,378	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003434	0.029935	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,426	12,434	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,009	13,600	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,435	26,034	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	415,528	415,528	415,528	415,528	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	389,048	389,048	389,048	389,048	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.025113	0.062653	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,770	24,375	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,205	50,409	0	0	10.00
11.00	Total number of injections/infusions (from your records)	39	340	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	518.08	148.26	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	99	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)	7,771	14,678	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)		70,614			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)		22,449			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 6/24/2022 9:41 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		407,829	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)		407,829	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		35,375	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		443,204	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: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 6/24/2022 9:41 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		23,334	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)		23,334	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		11,505	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		34,839	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: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 6/24/2022 9:41 am

RHC III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		3,697	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)		3,697	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		9,192	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		12,889	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: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-5 | Date/Time Prepared: 6/24/2022 9:41 am

RHC IV | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		591	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)		591	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		26,419	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		27,010	7.00

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