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: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/22/2021 9:50 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report Date: 11/22/2021 Time: 9:50 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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT WILLIAMSPORT (15-1307) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CHRISTOPHER HONS
Officer or Administrator of Provider(s)

VP OF FINANCE
Title

11/22/2021 09:50:06 AM
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	169,307	-174,881	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	163,469	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		122,933		0	10.00
10.01	RURAL HEALTH CLINIC II	0		284,211		0	10.01
200.00	Total	0	332,776	232,263	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 9:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 412 NORTH MONROE	PO Box:			1.00
2.00	City: WILLIAMSPORT	State: IN	Zip Code: 47993	County: WARREN	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	ASCENSION ST. VINCENT WILLIAMSPORT	151307	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT WILLIAMSPORT SWING BEDS	15Z307	99915		02/01/1988	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	NORTH CLINIC	153993	99915		05/06/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SOUTH CLINIC	153994	99915		08/01/2001	N	O	N	15.01
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	Y	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 9:50 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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.	1		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	10/01/2020	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
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 9:50 am

		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)				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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/22/2021 9:50 am

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

Line	Description	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

Line	Description	1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	102,352	0	0	118.01

Line	Description	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	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
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	15H046	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: ASCENSION ST. VINCENT	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 W. 96TH ST. SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 9:50 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/08/2021	Y	10/08/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 9:50 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?	Y		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.	Y		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.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3175833519	JILL.HILL1@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2021 9:50 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.	REIMBURSEMENT 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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2021 9:50 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	16	5,840	27,072.00	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)		16	5,840	27,072.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		16	5,840	27,072.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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

	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)	769	9	1,128			1.00
2.00	HMO and other (see instructions)	201	42				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	623	0	711			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,392	9	1,839			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		0	0			13.00
14.00	Total (see instructions)	1,392	9	1,839	0.00	66.64	14.00
15.00	CAH visits	10,187	600	30,602			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,430	101	6,768	0.00	11.88	26.00
26.01	RURAL HEALTH CLINIC II	3,728	140	12,964	0.00	17.76	26.01
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	96.28	27.00
28.00	Observation Bed Days		0	674			28.00
29.00	Ambulance Trips	477					29.00
30.00	Employee discount days (see instruction)			4			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2021 9:50 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	235	4	324	1.00
2.00	HMO and other (see instructions)			45	10		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	235	4	324	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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: 15-1307 Component CCN: 15-3993	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 11/22/2021 9:50 am
		RHC I	Cost

			1.00	
	Clinic Address and Identification			
1.00	Street		1731 RINGER LANE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WILLIAMSPORT	IN	47993	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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

		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	19:00	07:00	11.00

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

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

		Y/N	V	XVIII	XIX	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8
Component CCN: 15-3993		Date/Time Prepared: 11/22/2021 9:50 am
	RHC I	Cost

			County		
			4.00		
2.00	City, State, ZIP Code, County		WARREN		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	19:00	07:00	19:00	07:00	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-8 | Date/Time Prepared: 11/22/2021 9:50 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	440 W. SONGER LANE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	VEEDERSBURG	IN	47987	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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

		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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:50	07:00	11.00

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

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

		Y/N	V	XVIII	XIX	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8
Component CCN: 15-3994		Date/Time Prepared: 11/22/2021 9:50 am
	RHC II	Cost

		County		
		4.00		
2.00	City, State, ZIP Code, County	FOUNTAIN		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	17:50	07:00	17:50	07:00	17:50	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:50				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet S-10 | Date/Time Prepared: 11/22/2021 9:50 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)	0.270381	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	371,636	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	13,554,657	6.00
7.00	Medicaid cost (line 1 times line 6)	3,664,922	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)	3,293,286	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)	3,293,286	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)	1,150,246	314,232	1,464,478	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	311,005	314,232	625,237	21.00
22.00	Payments received from patients for amounts previously written off as charity care	104,546	0	104,546	22.00
23.00	Cost of charity care (line 21 minus line 22)	206,459	314,232	520,691	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)	2,322,330	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	280,619	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	431,721	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,890,609	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	662,287	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,182,978	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,476,264	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/22/2021 9:50 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		92,161	92,161	0	92,161	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		792,040	792,040	0	792,040	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	112,825	1,842,710	1,955,535	-967	1,954,568	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	465,302	5,456,603	5,921,905	-35,152	5,886,753	5.00
7.00	00700	OPERATION OF PLANT	0	774,746	774,746	99	774,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	345,346	345,346	12,324	357,670	9.00
10.00	01000	DIETARY	0	0	0	4,918	4,918	10.00
13.00	01300	NURSING ADMINISTRATION	9,716	0	9,716	0	9,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,244	15,244	1,055	16,299	14.00
15.00	01500	PHARMACY	150,702	356,901	507,603	0	507,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	91	91	0	91	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	970,633	151,152	1,121,785	-16,410	1,105,375	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	488,955	203,955	692,910	-16,267	676,643	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,790	181,399	755,189	433	755,622	54.00
60.00	06000	LABORATORY	0	1,403,210	1,403,210	0	1,403,210	60.00
65.00	06500	RESPIRATORY THERAPY	23,017	9,751	32,768	0	32,768	65.00
66.00	06600	PHYSICAL THERAPY	244,909	4,633	249,542	1,033	250,575	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,585	7,585	27,468	35,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	39,053	39,053	0	39,053	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	756,968	208,598	965,566	-55,976	909,590	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,480,157	375,919	1,856,076	81,525	1,937,601	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	859,366	1,692,626	2,551,992	-4,083	2,547,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	544,704	46,190	590,894	0	590,894	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,681,044	13,999,913	20,680,957	0	20,680,957	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	2,338	1,896	4,234	28,846	33,080	193.01
193.02	19303	ENT CLINIC	185,991	19,421	205,412	-28,846	176,566	193.02
194.00	07950	MARKETING	0	2,087	2,087	0	2,087	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,869,373	14,023,317	20,892,690	0	20,892,690	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A | Date/Time Prepared: 11/22/2021 9:50 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	92,161	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	792,040	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-62,407	1,892,161	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,887	5,965,640	5.00
7.00	00700	OPERATION OF PLANT	0	774,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	357,670	9.00
10.00	01000	DIETARY	0	4,918	10.00
13.00	01300	NURSING ADMINISTRATION	0	9,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,299	14.00
15.00	01500	PHARMACY	0	507,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	91	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-10,429	1,094,946	30.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-231,357	445,286	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-81,106	674,516	54.00
60.00	06000	LABORATORY	0	1,403,210	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,768	65.00
66.00	06600	PHYSICAL THERAPY	0	250,575	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	39,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-28,730	880,860	88.00
88.01	08801	RURAL HEALTH CLINIC II	-89,345	1,848,256	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	2,547,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-81	590,813	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-424,568	20,256,389	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ORTHO CLINIC	41,154	74,234	193.01
193.02	19303	ENT CLINIC	0	176,566	193.02
194.00	07950	MARKETING	0	2,087	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-383,414	20,509,276	200.00

RECLASSIFICATIONS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/22/2021 9:50 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	27,468	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	27,468	
	B - PANDEMIC				
1.00	OPERATION OF PLANT	7.00		99	1.00
2.00	HOUSEKEEPING	9.00		12,324	2.00
3.00	DIETARY	10.00		4,918	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		1,055	4.00
			0	18,396	
	C - PANDEMIC SALARIES				
1.00	ADULTS & PEDIATRICS	30.00	5,121		1.00
2.00	OPERATING ROOM	50.00	2,240		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	402		3.00
4.00	PHYSICAL THERAPY	66.00	960		4.00
5.00	RURAL HEALTH CLINIC	88.00	1,401		5.00
6.00	EMERGENCY	91.00	2,591		6.00
			12,715	0	
	D - PANDEMIC BENEFITS				
1.00	ADULTS & PEDIATRICS	30.00	0	389	1.00
2.00	OPERATING ROOM	50.00	0	170	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31	3.00
4.00	PHYSICAL THERAPY	66.00	0	73	4.00
5.00	RURAL HEALTH CLINIC	88.00	0	107	5.00
6.00	EMERGENCY	91.00	0	197	6.00
	TOTALS		0	967	
	E - VACCINE ADVERSE REACTION				
1.00	RURAL HEALTH CLINIC	88.00	0	2,489	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	1,552	2.00
	TOTALS		0	4,041	
	F - PANDEMIC WORKERS COMP				
1.00	RURAL HEALTH CLINIC	88.00		1,481	1.00
			0	1,481	
	G - CLINIC WAGES				
1.00	ORTHO CLINIC	193.01	28,846		1.00
			28,846	0	
	H - RHC WAGES - DR. TRICOCI				
1.00	RURAL HEALTH CLINIC II	88.01	79,973	0	1.00
	TOTALS		79,973	0	
	I - RHC WAGES - DR. SHARMA				
1.00	RURAL HEALTH CLINIC	88.00	20,000	0	1.00
	TOTALS		20,000	0	
500.00	Grand Total: Increases		141,534	52,353	500.00

RECLASSIFICATIONS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-6 | Date/Time Prepared: 11/22/2021 9:50 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,920	0	1.00
2.00	OPERATING ROOM	50.00	0	18,677	0	2.00
3.00	EMERGENCY	91.00	0	6,871	0	3.00
	TOTALS		0	27,468		
	B - PANDEMIC					
1.00	ADMINISTRATIVE & GENERAL	5.00		18,396		1.00
2.00						2.00
3.00						3.00
4.00						4.00
			0	18,396		
	C - PANDEMIC SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	12,715			1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
			12,715	0		
	D - PANDEMIC BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	967	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		0	967		
	E - VACCINE ADVERSE REACTION					
1.00	ADMINISTRATIVE & GENERAL	5.00	4,041	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		4,041	0		
	F - PANDEMIC WORKERS COMP					
1.00	RURAL HEALTH CLINIC	88.00	1,481			1.00
			1,481	0		
	G - CLINIC WAGES					
1.00	ENT CLINIC	193.02	28,846			1.00
			28,846	0		
	H - RHC WAGES - DR. TRICOCI					
1.00	RURAL HEALTH CLINIC	88.00	79,973	0	0	1.00
	TOTALS		79,973	0		
	I - RHC WAGES - DR. SHARMA					
1.00	ADULTS & PEDIATRICS	30.00	20,000	0	0	1.00
	TOTALS		20,000	0		
500.00	Grand Total: Decreases		147,056	46,831		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part I Date/Time Prepared: 11/22/2021 9:50 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	128,894	0	0	0	0	1.00
2.00	Land Improvements	253,215	95,282	0	95,282	0	2.00
3.00	Buildings and Fixtures	8,944,698	100,946	0	100,946	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,772,753	0	0	0	0	5.00
6.00	Movable Equipment	4,678,098	1,037,855	0	1,037,855	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,777,658	1,234,083	0	1,234,083	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,777,658	1,234,083	0	1,234,083	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	128,894	0	1.00
2.00	Land Improvements	348,497	0	2.00
3.00	Buildings and Fixtures	9,045,644	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,772,753	0	5.00
6.00	Movable Equipment	5,715,953	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,011,741	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,011,741	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part II Date/Time Prepared: 11/22/2021 9:50 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	46,179	0	0	41,883	4,099	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	685,050	106,990	0	0	0	2.00
3.00	Total (sum of lines 1-2)	731,229	106,990	0	41,883	4,099	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	92,161	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	792,040	2.00
3.00	Total (sum of lines 1-2)	0	884,201	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2021 9:50 am

	Cost Center Description	COMPUTATION OF RATIOS Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL 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	11,295,788	0	11,295,788	0.664000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,715,953	0	5,715,953	0.336000	0	2.00
3.00	Total (sum of lines 1-2)	17,011,741	0	17,011,741	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL 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	46,179	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	685,050	106,990	2.00
3.00	Total (sum of lines 1-2)	0	0	0	731,229	106,990	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	41,883	4,099	0	92,161	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	792,040	2.00
3.00	Total (sum of lines 1-2)	0	41,883	4,099	0	884,201	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/22/2021 9:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-122,327	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-7,611	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-91,566			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	1,756,523			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8 | Date/Time Prepared: 11/22/2021 9:50 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Corporate Sponsorship	A	-5,552	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	Promotional	A	-2,682	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	Promotional	A	-81	AMBULANCE SERVICES	95.00	0	33.02
33.03	Provider Tax	A	-1,207,154	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	Lobbying	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Physician Fund	A	-203,563	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	Mid Level Providers - A&P	A	-10,429	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	Mid Level Providers - Anesthesiologist	A	-220,897	OPERATING ROOM	50.00	0	33.07
33.08	Mission Point Savings	B	-74,312	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	Rev Offset - Admin	B	-116,368	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	NON-RHC PHYSICIAN COSTS	A	-28,730	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	NON-RHC PHYSICIAN COSTS	A	-89,345	RURAL HEALTH CLINIC II	88.01	0	33.11
33.12	ORTHO CLINIC WAGES	A	41,154	ORTHO CLINIC	193.01	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-383,414				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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2021 9:50 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	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	288,880	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	6,063	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	5,181,517	3,731,842	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASVH Chargebacks	2,751	2,751	3.01
3.02	15.00	PHARMACY	ASVH CHARGEBACKS	4,000	4,000	3.02
3.03	30.00	ADULTS & PEDIATRICS	ASVH CHARGEBACKS	5,715	5,715	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	ASVH CHARGEBACKS	25,591	25,591	3.04
3.05	0.00			0	0	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	1,241,953	1,230,048	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	Interest Expense	122,327	0	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	1,548	123,875	3.08
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.			6,880,345	5,123,822	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	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:	HOME OFFICE				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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2021 9:50 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	288,880	0	1.00
2.00	6,063	0	2.00
3.00	1,449,675	0	3.00
3.01	0	0	3.01
3.02	0	0	3.02
3.03	0	0	3.03
3.04	0	0	3.04
3.05	0	0	3.05
3.06	11,905	0	3.06
3.07	122,327	11	3.07
3.08	-122,327	0	3.08
4.00	0	0	4.00
5.00	1,756,523		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	ADMINISTRATION	6.00
7.00	ADMINISTRATION	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2021 9:50 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	0.00		0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	10,460	10,460	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	81,106	81,106	0	0	0	3.00
4.00	91.00	EMERGENCY	1,613,508	0	1,613,508	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,705,074	91,566	1,613,508		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	0.00		0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	50.00	OPERATING ROOM	0	0	0	10,460		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	81,106		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	91,566		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/22/2021 9:50 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	92,161	92,161				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	792,040		792,040			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,892,161	0	0	1,892,161		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,965,640	6,555	56,335	125,718	6,154,248	5.00
7.00	00700	OPERATION OF PLANT	774,845	12,924	111,082	0	898,851	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	363	3,117	0	3,480	8.00
9.00	00900	HOUSEKEEPING	357,670	90	772	0	358,532	9.00
10.00	01000	DIETARY	4,918	0	0	0	4,918	10.00
13.00	01300	NURSING ADMINISTRATION	9,716	962	8,268	2,723	21,669	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,299	0	0	0	16,299	14.00
15.00	01500	PHARMACY	507,603	0	0	42,238	549,841	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91	1,985	17,056	0	19,132	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,094,946	12,188	104,742	267,877	1,479,753	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,286	7,553	64,915	137,671	655,425	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,516	6,073	52,193	160,933	893,715	54.00
60.00	06000	LABORATORY	1,403,210	2,439	20,960	0	1,426,609	60.00
65.00	06500	RESPIRATORY THERAPY	32,768	1,700	14,607	6,451	55,526	65.00
66.00	06600	PHYSICAL THERAPY	250,575	3,619	31,099	68,912	354,205	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,053	969	8,328	0	44,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,053	0	0	0	39,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	820	7,051	0	7,871	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	880,860	7,897	67,869	195,330	1,151,956	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,848,256	11,214	96,370	437,267	2,393,107	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,547,909	6,303	54,167	241,588	2,849,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	590,813	5,064	43,524	152,669	792,070	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,256,389	88,718	762,455	1,839,377	20,170,577	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	74,234	978	8,402	8,740	92,354	193.01
193.02	19303	ENT CLINIC	176,566	2,465	21,183	44,044	244,258	193.02
194.00	07950	MARKETING	2,087	0	0	0	2,087	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,509,276	92,161	792,040	1,892,161	20,509,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I | Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,154,248					5.00
7.00	00700	OPERATION OF PLANT	385,353	1,284,204				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,492	10,118	15,090			8.00
9.00	00900	HOUSEKEEPING	153,709	2,505	0	514,746		9.00
10.00	01000	DIETARY	2,108	0	0	0	7,026	10.00
13.00	01300	NURSING ADMINISTRATION	9,290	26,836	0	6,857	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,988	0	0	0	0	14.00
15.00	01500	PHARMACY	235,726	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,202	55,357	0	14,144	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	634,395	339,950	6,889	86,859	7,026	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	280,992	210,686	1,715	53,831	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,151	169,396	634	43,281	0	54.00
60.00	06000	LABORATORY	611,612	68,028	0	17,381	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,805	47,408	0	12,113	0	65.00
66.00	06600	PHYSICAL THERAPY	151,854	100,934	1,154	25,789	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,014	27,028	0	6,906	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,743	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,374	22,885	0	5,847	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	493,863	0	291	56,280	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,025,966	0	243	79,915	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,221,830	175,804	3,681	44,918	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	339,574	0	483	36,092	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,009,041	1,256,935	15,090	490,213	7,026	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	39,594	27,269	0	6,967	0	193.01
193.02	19303	ENT CLINIC	104,718	0	0	17,566	0	193.02
194.00	07950	MARKETING	895	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,154,248	1,284,204	15,090	514,746	7,026	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	64,652					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,287				14.00
15.00	01500	PHARMACY	0	0	785,567			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	96,835		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,678	0	0	7,458	2,589,008	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,377	0	0	7,994	1,218,020	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,660	1,509,837	54.00
60.00	06000	LABORATORY	0	0	0	21,369	2,144,999	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,270	141,122	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,001	636,937	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,015	0	0	108,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,272	0	0	68,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	785,567	0	825,544	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,976	1,704,366	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,309	3,503,540	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	25,862	0	0	23,611	4,345,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	5,187	1,173,406	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,917	23,287	785,567	96,835	19,968,833	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	166,184	193.01
193.02	19303	ENT CLINIC	4,735	0	0	0	371,277	193.02
194.00	07950	MARKETING	0	0	0	0	2,982	194.00
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)	64,652	23,287	785,567	96,835	20,509,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part I Date/Time Prepared: 11/22/2021 9:50 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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	2,589,008	30.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,218,020	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,509,837	54.00
60.00	06000	LABORATORY	0	2,144,999	60.00
65.00	06500	RESPIRATORY THERAPY	0	141,122	65.00
66.00	06600	PHYSICAL THERAPY	0	636,937	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	108,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	68,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	825,544	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	1,704,366	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,503,540	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	4,345,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	1,173,406	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,968,833	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ORTHO CLINIC	0	166,184	193.01
193.02	19303	ENT CLINIC	0	371,277	193.02
194.00	07950	MARKETING	0	2,982	194.00
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	20,509,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/22/2021 9:50 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	412,755	6,555	56,335	475,645	0	5.00
7.00	00700	OPERATION OF PLANT	0	12,924	111,082	124,006	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	363	3,117	3,480	0	8.00
9.00	00900	HOUSEKEEPING	0	90	772	862	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	962	8,268	9,230	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,985	17,056	19,041	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,188	104,742	116,930	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,553	64,915	72,468	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,073	52,193	58,266	0	54.00
60.00	06000	LABORATORY	0	2,439	20,960	23,399	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,700	14,607	16,307	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,619	31,099	34,718	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	969	8,328	9,297	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	820	7,051	7,871	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,897	67,869	75,766	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,214	96,370	107,584	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	6,303	54,167	60,470	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,064	43,524	48,588	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	412,755	88,718	762,455	1,263,928	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	978	8,402	9,380	0	193.01
193.02	19303	ENT CLINIC	0	2,465	21,183	23,648	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	412,755	92,161	792,040	1,296,956	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	475,645					5.00
7.00	00700	OPERATION OF PLANT	29,783	153,789				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115	1,212	4,807			8.00
9.00	00900	HOUSEKEEPING	11,880	300	0	13,042		9.00
10.00	01000	DIETARY	163	0	0	0	163	10.00
13.00	01300	NURSING ADMINISTRATION	718	3,214	0	174	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	540	0	0	0	0	14.00
15.00	01500	PHARMACY	18,218	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	634	6,629	0	358	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,030	40,709	2,194	2,201	163	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,717	25,231	546	1,364	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,612	20,286	202	1,097	0	54.00
60.00	06000	LABORATORY	47,269	8,147	0	440	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,840	5,677	0	307	0	65.00
66.00	06600	PHYSICAL THERAPY	11,736	12,087	368	653	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,469	3,237	0	175	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,294	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261	2,741	0	148	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,169	0	93	1,426	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	79,293	0	77	2,025	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	94,438	21,053	1,173	1,138	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,244	0	154	914	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	464,423	150,523	4,807	12,420	163	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	3,060	3,266	0	177	0	193.01
193.02	19303	ENT CLINIC	8,093	0	0	445	0	193.02
194.00	07950	MARKETING	69	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	475,645	153,789	4,807	13,042	163	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	13,336					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	540				14.00
15.00	01500	PHARMACY	0	0	18,218			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	26,662		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,502	0	0	2,052	218,781	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,522	0	0	2,200	125,048	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,409	114,872	54.00
60.00	06000	LABORATORY	0	0	0	5,879	85,134	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	624	24,755	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	826	60,388	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	255	0	0	14,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	285	0	0	1,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,218	0	29,239	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	544	115,998	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,186	190,165	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,335	0	0	6,515	190,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,427	77,327	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,359	540	18,218	26,662	1,247,841	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	15,883	193.01
193.02	19303	ENT CLINIC	977	0	0	0	33,163	193.02
194.00	07950	MARKETING	0	0	0	0	69	194.00
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)	13,336	540	18,218	26,662	1,296,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B Part II | Date/Time Prepared: 11/22/2021 9:50 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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	218,781	30.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	125,048	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,872	54.00
60.00	06000	LABORATORY	0	85,134	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,755	65.00
66.00	06600	PHYSICAL THERAPY	0	60,388	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,239	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	115,998	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	190,165	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	190,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	77,327	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,247,841	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ORTHO CLINIC	0	15,883	193.01
193.02	19303	ENT CLINIC	0	33,163	193.02
194.00	07950	MARKETING	0	69	194.00
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	1,296,956	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	53,356					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		53,356				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,751,026			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,795	3,795	448,546	-6,154,248	14,355,028	5.00
7.00	00700	OPERATION OF PLANT	7,483	7,483	0	0	898,851	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	210	0	0	3,480	8.00
9.00	00900	HOUSEKEEPING	52	52	0	0	358,532	9.00
10.00	01000	DIETARY	0	0	0	0	4,918	10.00
13.00	01300	NURSING ADMINISTRATION	557	557	9,716	0	21,669	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	16,299	14.00
15.00	01500	PHARMACY	0	0	150,702	0	549,841	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,149	1,149	0	0	19,132	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,056	7,056	955,754	0	1,479,753	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,373	4,373	491,195	0	655,425	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516	3,516	574,192	0	893,715	54.00
60.00	06000	LABORATORY	1,412	1,412	0	0	1,426,609	60.00
65.00	06500	RESPIRATORY THERAPY	984	984	23,017	0	55,526	65.00
66.00	06600	PHYSICAL THERAPY	2,095	2,095	245,869	0	354,205	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	44,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	39,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	475	0	0	7,871	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,572	4,572	696,915	0	1,151,956	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,492	6,492	1,560,130	0	2,393,107	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,649	3,649	861,957	0	2,849,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,932	2,932	544,704	0	792,070	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,363	51,363	6,562,697	-6,154,248	14,016,329	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	566	566	31,184	0	92,354	193.01
193.02	19303	ENT CLINIC	1,427	1,427	157,145	0	244,258	193.02
194.00	07950	MARKETING	0	0	0	0	2,087	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	92,161	792,040	1,892,161		6,154,248	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.727285	14.844441	0.280278		0.428717	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		475,645	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.033134	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	26,655					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	94,695				8.00
9.00	00900	HOUSEKEEPING	52	0	41,816			9.00
10.00	01000	DIETARY	0	0	0	100		10.00
13.00	01300	NURSING ADMINISTRATION	557	0	557	0	50,613	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,149	0	1,149	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,056	43,230	7,056	100	20,885	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,373	10,765	4,373	0	5,775	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516	3,980	3,516	0	0	54.00
60.00	06000	LABORATORY	1,412	0	1,412	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	984	0	984	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,095	7,240	2,095	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	0	561	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	475	0	475	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,826	4,572	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,524	6,492	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,649	23,100	3,649	0	20,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,030	2,932	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,089	94,695	39,823	100	46,906	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	566	0	566	0	0	193.01
193.02	19303	ENT CLINIC	0	0	1,427	0	3,707	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,284,204	15,090	514,746	7,026	64,652	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.178728	0.159354	12.309786	70.260000	1.277379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	153,789	4,807	13,042	163	13,336	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.769612	0.050763	0.311890	1.630000	0.263490	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet B-1 | Date/Time Prepared: 11/22/2021 9:50 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (DIRECT COSTS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,106				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	69,586,116		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	5,357,985		30.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	5,742,912		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,123,575		54.00
60.00	06000	LABORATORY	0	0	15,350,976		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,630,400		65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,155,829		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,053	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,053	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	1,419,491		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	3,095,891		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	16,983,108		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	3,725,949		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,106	100	69,586,116		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ORTHO CLINIC	0	0	0		193.01
193.02	19303	ENT CLINIC	0	0	0		193.02
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	23,287	785,567	96,835		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.314239	7,855.670000	0.001392		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	540	18,218	26,662		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007287	182.180000	0.000383		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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I | Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,589,008		2,589,008	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,218,020		1,218,020	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,837		1,509,837	0	0	54.00
60.00	06000	LABORATORY	2,144,999		2,144,999	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	141,122	0	141,122	0	0	65.00
66.00	06600	PHYSICAL THERAPY	636,937	0	636,937	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,313		108,313	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	68,068		68,068	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	825,544		825,544	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,704,366		1,704,366	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,503,540		3,503,540	0	0	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,345,673		4,345,673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	694,382		694,382		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,173,406		1,173,406	0	0	95.00
200.00		Subtotal (see instructions)	20,663,215	0	20,663,215	0	0	200.00
201.00		Less Observation Beds	694,382		694,382		0	201.00
202.00		Total (see instructions)	19,968,833	0	19,968,833	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 9:50 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	3,976,036		3,976,036			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,692	5,470,220	5,742,912	0.212091	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,191	13,449,384	14,123,575	0.106902	0.000000	54.00
60.00	06000	LABORATORY	1,143,940	14,207,036	15,350,976	0.139730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	49,751	1,580,649	1,630,400	0.086557	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	243,161	1,912,668	2,155,829	0.295449	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,047	809,334	1,423,381	0.076096	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,010	117,940	128,950	0.527864	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	920,016	1,796,017	2,716,033	0.303952	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,419,491	1,419,491			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,095,891	3,095,891			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	116,597	16,866,511	16,983,108	0.255882	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,282	1,358,667	1,381,949	0.502466	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,531	3,720,419	3,725,950	0.314928	0.000000	95.00
200.00		Subtotal (see instructions)	8,050,254	65,804,227	73,854,481			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,050,254	65,804,227	73,854,481			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 9:50 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,589,008		2,589,008	0	2,589,008	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,218,020		1,218,020	0	1,218,020	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,509,837		1,509,837	0	1,509,837	54.00
60.00	06000	LABORATORY	2,144,999		2,144,999	0	2,144,999	60.00
65.00	06500	RESPIRATORY THERAPY	141,122	0	141,122	0	141,122	65.00
66.00	06600	PHYSICAL THERAPY	636,937	0	636,937	0	636,937	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,313		108,313	0	108,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	68,068		68,068	0	68,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	825,544		825,544	0	825,544	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,704,366		1,704,366	0	1,704,366	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,503,540		3,503,540	0	3,503,540	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,345,673		4,345,673	0	4,345,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	694,382		694,382		694,382	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,173,406		1,173,406	0	1,173,406	95.00
200.00		Subtotal (see instructions)	20,663,215	0	20,663,215	0	20,663,215	200.00
201.00		Less Observation Beds	694,382		694,382		694,382	201.00
202.00		Total (see instructions)	19,968,833	0	19,968,833	0	19,968,833	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | 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	3,976,036		3,976,036			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,692	5,470,220	5,742,912	0.212091	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,191	13,449,384	14,123,575	0.106902	0.000000	54.00
60.00	06000	LABORATORY	1,143,940	14,207,036	15,350,976	0.139730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	49,751	1,580,649	1,630,400	0.086557	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	243,161	1,912,668	2,155,829	0.295449	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,047	809,334	1,423,381	0.076096	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,010	117,940	128,950	0.527864	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	920,016	1,796,017	2,716,033	0.303952	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,419,491	1,419,491	1.200688	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,095,891	3,095,891	1.131674	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	116,597	16,866,511	16,983,108	0.255882	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,282	1,358,667	1,381,949	0.502466	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,531	3,720,419	3,725,950	0.314928	0.000000	95.00
200.00		Subtotal (see instructions)	8,050,254	65,804,227	73,854,481			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,050,254	65,804,227	73,854,481			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet C Part I Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part II Date/Time Prepared: 11/22/2021 9:50 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	125,048	5,742,912	0.021774	125,160	2,725	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,872	14,123,575	0.008133	295,609	2,404	54.00
60.00	06000	LABORATORY	85,134	15,350,976	0.005546	517,875	2,872	60.00
65.00	06500	RESPIRATORY THERAPY	24,755	1,630,400	0.015183	20,512	311	65.00
66.00	06600	PHYSICAL THERAPY	60,388	2,155,829	0.028011	49,958	1,399	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,433	1,423,381	0.010140	265,649	2,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,579	128,950	0.012245	9,861	121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,239	2,716,033	0.010765	410,798	4,422	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	115,998	1,419,491	0.081718	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	190,165	3,095,891	0.061425	0	0	88.01
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	190,122	16,983,108	0.011195	634	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	58,678	1,381,949	0.042460	15,039	639	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,010,411	66,152,495		1,711,095	17,594	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,742,912	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,123,575	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,350,976	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,630,400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,155,829	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,423,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	128,950	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,716,033	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,419,491	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,095,891	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	16,983,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,381,949	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	66,152,495		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/22/2021 9:50 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 before Geo Reclassification	Outpatient Program Charges on/after Geo Reclassification	
			9.00	10.00	11.00	12.00	12.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	125,160	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	295,609	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	517,875	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	20,512	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,958	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	265,649	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	9,861	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	410,798	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	634	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	15,039	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,711,095	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307

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

Worksheet D Part IV

Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geo Reclassification	
			13.00	13.01	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 9:50 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.) before Geo Reclassification	Charges: PPS Reimbursed Services (see inst.) on/after Geo Reclassification	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	4.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212091	0	0	1,699,043	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106902	0	0	4,209,774	0	54.00
60.00	06000	LABORATORY	0.139730	0	0	5,323,415	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.086557	0	0	610,264	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295449	0	0	632,185	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076096	0	0	319,711	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.527864	0	0	38,042	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303952	0	0	435,146	2,880	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.255882	0	0	4,132,661	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502466	0	0	485,992	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.314928			0		95.00
200.00		Subtotal (see instructions)		0	0	17,886,233	2,880	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	0	17,886,233	2,880	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs					
			PPS Services (see inst.) before Geo Reclassification	PPS Services (see inst.) on/after Geo Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	360,352	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	450,033	0		54.00
60.00	06000	LABORATORY	0	0	743,841	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	52,823	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	186,778	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,329	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	20,081	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	132,263	875		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	1,057,474	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	244,194	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			0			95.00
200.00		Subtotal (see instructions)	0	0	3,272,168	875		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 - line 201)	0	0	3,272,168	875		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
				PPS Reimbursed Services (see inst.) before Geo Reclassification	PPS Reimbursed Services (see inst.) on/after Geo Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	4.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212091	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106902	0	0	0	0	54.00
60.00	06000	LABORATORY	0.139730	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.086557	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295449	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076096	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.527864	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303952	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.255882	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502466	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.314928			0		95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part V | Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see inst.) before Geo Reclassification	PPS Services (see inst.) on/after Geo Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			0			95.00
200.00		Subtotal (see instructions)	0	0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 - line 201)	0	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part III Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	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
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	1,802	0.00	9	30.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	1,802		9	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
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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,742,912	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,123,575	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,350,976	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,630,400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,155,829	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,423,381	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	128,950	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,716,033	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,419,491	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,095,891	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	16,983,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,381,949	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	66,152,495		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | 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 before Geo Reclassification	Outpatient Program Charges on/after Geo Reclassification	
			9.00	10.00	11.00	12.00	12.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,313	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	31,744	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,924	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,098	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	10,291	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	26,999	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)		107,369	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D Part IV | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geo Reclassification	
			13.00	13.01	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (lines 50 through 199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/22/2021 9:50 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)	2,513	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,802	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,128	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	353	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)	358	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	769	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)	353	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)	270	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	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,589,008	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	732,508	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,856,500	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)	1,856,500	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,030.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	792,262	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)	792,262	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 9:50 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						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)	305,046	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,097,308	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)	363,678	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	278,168	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	641,846	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)	674	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,030.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	694,382	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 9:50 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	218,781	2,589,008	0.084504	694,382	58,678	90.00
91.00	Nursing School cost	0	2,589,008	0.000000	694,382	0	91.00
92.00	Allied health cost	0	2,589,008	0.000000	694,382	0	92.00
93.00	All other Medical Education	0	2,589,008	0.000000	694,382	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,513	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,802	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,128	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	353	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)	358	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,589,008	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	732,508	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,856,500	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)	1,856,500	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,030.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,272	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)	9,272	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	18,499	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	27,771	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	674	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,030.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	694,382	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-1 | Date/Time Prepared: 11/22/2021 9:50 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	218,781	2,589,008	0.084504	694,382	58,678	90.00
91.00	Nursing School cost	0	2,589,008	0.000000	694,382	0	91.00
92.00	Allied health cost	0	2,589,008	0.000000	694,382	0	92.00
93.00	All other Medical Education	0	2,589,008	0.000000	694,382	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/22/2021 9:50 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		1,983,594		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.212091	125,160	26,545	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106902	295,609	31,601	54.00
60.00	06000	LABORATORY	0.139730	517,875	72,363	60.00
65.00	06500	RESPIRATORY THERAPY	0.086557	20,512	1,775	65.00
66.00	06600	PHYSICAL THERAPY	0.295449	49,958	14,760	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076096	265,649	20,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.527864	9,861	5,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303952	410,798	124,863	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.255882	634	162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502466	15,039	7,557	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)		1,711,095	305,046	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)		1,711,095		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3

Component CCN: 15-Z307 | Date/Time Prepared: 11/22/2021 9:50 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.212091	63,891	13,551	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106902	194,286	20,770	54.00
60.00	06000	LABORATORY	0.139730	332,640	46,480	60.00
65.00	06500	RESPIRATORY THERAPY	0.086557	11,656	1,009	65.00
66.00	06600	PHYSICAL THERAPY	0.295449	146,055	43,152	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076096	210,192	15,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.527864	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303952	238,665	72,543	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.255882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502466	8,243	4,142	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)		1,205,628	217,642	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)		1,205,628		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet D-3 | Date/Time Prepared: 11/22/2021 9:50 am

			Title XIX	Hospital	Cost	
		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		23,114		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.212091	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106902	35,313	3,775	54.00
60.00	06000	LABORATORY	0.139730	31,744	4,436	60.00
65.00	06500	RESPIRATORY THERAPY	0.086557	1,924	167	65.00
66.00	06600	PHYSICAL THERAPY	0.295449	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076096	1,098	84	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.527864	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.303952	10,291	3,128	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.200688	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.131674	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	COVID-19 VACCINE CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.255882	26,999	6,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.502466	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)		107,369	18,499	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)		107,369		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E Part B Date/Time Prepared: 11/22/2021 9:50 am

Title XVIII | Hospital | Cost

		before Geo Reclassification	on/after Geo Reclassification	
		1.00	1.01	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	3,273,043		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	0	2.00
3.00	OPPS payments	0	0	3.00
4.00	Outlier payment (see instructions)	0	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	0.000	5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	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)	3,273,043		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)	3,305,773		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)	33,375		25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,279,098		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)	993,300		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)	993,300		30.00
31.00	Primary payer payments	307		31.00
32.00	Subtotal (line 30 minus line 31)	992,993		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)	419,929		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	272,954		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	285,418		36.00
37.00	Subtotal (see instructions)	1,265,947		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)	1,265,947		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	1,440,828		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)	-174,881		43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		44.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/22/2021 9:50 am
	Title XVIII	Hospital	Cost

		before Geo Reclassification	on/after Geo Reclassification	
		1.00	1.01	
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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2021 9:50 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		719,655		1,440,828	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		719,655		1,440,828	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		169,307		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		174,881	6.02
7.00	Total Medicare program liability (see instructions)		888,962		1,265,947	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: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2021 9:50 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		694,762		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		694,762		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		163,469		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		858,231		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: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/22/2021 9:50 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet E-2 | Date/Time Prepared: 11/22/2021 9:50 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)	648,264	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)	219,818	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	623	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)	868,082	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	868,082	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)	868,082	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,851	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	858,231	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)	858,231	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	694,762	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)	163,469	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: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/22/2021 9:50 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,097,308	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,097,308	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,108,281	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,108,281	19.00
20.00	Deductibles (exclude professional component)	226,984	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	881,297	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	881,297	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,792	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,665	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	152	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	888,962	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	888,962	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	719,655	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)	169,307	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2021 9:50 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	27,771		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	27,771	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	27,771	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	23,114		8.00
9.00	Ancillary service charges	107,369	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	130,483	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	130,483	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	102,712	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	27,771	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	27,771	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	27,771	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	27,771	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	27,771	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	27,771	0	40.00
41.00	Interim payments	27,771	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G | Date/Time Prepared: 11/22/2021 9:50 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	238,439	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,636,340	0	0	0	4.00
5.00	Other receivable	56,011	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,474,643	0	0	0	6.00
7.00	Inventory	348,191	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	511,027	0	0	0	9.00
10.00	Due from other funds	564,030	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,879,395	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	128,894	0	0	0	12.00
13.00	Land improvements	348,497	0	0	0	13.00
14.00	Accumulated depreciation	-162,861	0	0	0	14.00
15.00	Buildings	9,045,644	0	0	0	15.00
16.00	Accumulated depreciation	-5,672,033	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	1,772,753	0	0	0	19.00
20.00	Accumulated depreciation	-1,117,336	0	0	0	20.00
21.00	Automobiles and trucks	51,450	0	0	0	21.00
22.00	Accumulated depreciation	-51,450	0	0	0	22.00
23.00	Major movable equipment	5,664,504	0	0	0	23.00
24.00	Accumulated depreciation	-4,019,805	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)	5,988,257	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	251,935	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	64,995	234,891	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	316,930	234,891	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,184,582	234,891	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	411,913	0	0	0	37.00
38.00	Salaries, wages, and fees payable	663,168	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	59,210	0	0	0	40.00
41.00	Deferred income	444,380	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	5,401,079	0	0	0	43.00
44.00	Other current liabilities	941,810	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,921,560	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	3,625,578	0	0	0	48.00
49.00	Other long term liabilities	204,877	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,830,455	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,752,015	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,567,433				52.00
53.00	Specific purpose fund		234,891			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)	-1,567,433	234,891	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,184,582	234,891	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-1 | Date/Time Prepared: 11/22/2021 9:50 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		-1,316,288		234,891		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		331,014				2.00
3.00	Total (sum of line 1 and line 2)		-985,274		234,891		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	Contributions/Donations/Grant Revenue	133,517		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)		133,517		0		10.00
11.00	Subtotal (line 3 plus line 10)		-851,757		234,891		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	Released Capital	715,675		0		0	16.00
17.00	Rounding	1		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		715,676		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,567,433		234,891		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00	Contributions/Donations/Grant Revenue		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	Released Capital		0		16.00
17.00	Rounding		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: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/22/2021 9:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,357,939		4,357,939	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)	4,357,939		4,357,939	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,357,939		4,357,939	17.00
18.00	Ancillary services	3,928,807	39,310,236	43,239,043	18.00
19.00	Outpatient services	120,661	18,226,157	18,346,818	19.00
20.00	RURAL HEALTH CLINIC	0	1,419,491	1,419,491	20.00
20.01	RURAL HEALTH CLINIC II	0	3,095,891	3,095,891	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	5,531	3,720,419	3,725,950	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	0	0	27.00
27.01	Other Patient Service Revenue - NRCCs	0	557,459	557,459	27.01
27.02	OTHER (SPECIFY)	0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,412,938	66,329,653	74,742,591	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,892,690		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)		20,892,690		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1307	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/22/2021 9:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,742,591	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,384,078	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,358,513	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,892,690	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-534,177	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-5,000	6.00
7.00	Income from investments	211	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	617	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	1,730	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Other - Credentialing	1,628	24.01
24.02	Other - Pharmacy Services	0	24.02
24.04	Rental Income - ENT Clinic	135,170	24.04
24.06	Other	49,140	24.06
24.14	Other - Food Services	4,660	24.14
24.15	Other - State Program Revenue	17,000	24.15
24.19	Other - South Clinic	8,274	24.19
24.23	Other - Phys Fund Rev IC	200,029	24.23
24.24	Other - Unclaimed Property Exemptions	14,881	24.24
24.25	Other - Contract Services Revenue	379,667	24.25
24.26	Other - Late Penalty Fees	190	24.26
24.28	Other - Shared Savings Payments	72,685	24.28
24.50	COVID-19 PHE Funding	-15,691	24.50
25.00	Total other income (sum of lines 6-24)	865,191	25.00
26.00	Total (line 5 plus line 25)	331,014	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)	331,014	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1

Component CCN: 15-3993 | Date/Time Prepared: 11/22/2021 9:50 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	209,548	0	209,548	-65,040	144,508	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	183,332	0	183,332	-3,295	180,037	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	248,989	0	248,989	496	249,485	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	115,099	0	115,099	229	115,328	9.00
10.00	Subtotal (sum of lines 1 through 9)	756,968	0	756,968	-67,610	689,358	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	5,063	5,063	0	5,063	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	203,535	203,535	2,490	206,025	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	208,598	208,598	2,490	211,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	756,968	208,598	965,566	-65,120	900,446	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	9,144	9,144	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	9,144	9,144	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	756,968	208,598	965,566	-55,976	909,590	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1 | Date/Time Prepared: 11/22/2021 9:50 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	-28,730	115,778	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	180,037	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	249,485	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	115,328	9.00
10.00	Subtotal (sum of lines 1 through 9)	-28,730	660,628	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	5,063	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	206,025	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	211,088	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-28,730	871,716	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	9,144	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	9,144	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-28,730	880,860	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1

Component CCN: 15-3994 | Date/Time Prepared: 11/22/2021 9:50 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	686,644	0	686,644	70,716	757,360	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	247,901	0	247,901	-1,724	246,177	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	430,419	0	430,419	0	430,419	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	115,193	0	115,193	0	115,193	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,480,157	0	1,480,157	68,992	1,549,149	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	10,061	10,061	0	10,061	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	365,858	365,858	1,553	367,411	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	375,919	375,919	1,553	377,472	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,480,157	375,919	1,856,076	70,545	1,926,621	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	10,980	10,980	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	10,980	10,980	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,480,157	375,919	1,856,076	81,525	1,937,601	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-1

Component CCN: 15-3994 | Date/Time Prepared: 11/22/2021 9:50 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	-89,345	668,015	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	246,177	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	430,419	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	115,193	9.00
10.00	Subtotal (sum of lines 1 through 9)	-89,345	1,459,804	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	10,061	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	367,411	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	377,472	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-89,345	1,837,276	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	10,980	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	10,980	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-89,345	1,848,256	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-2

Component CCN: 15-3993 | Date/Time Prepared: 11/22/2021 9:50 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.51	2,872	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.60	3,896	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.11	6,768		3	6,768	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)	2.11	6,768			6,768	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)	871,716	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	9,144	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	880,860	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.989619	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	823,506	15.00
16.00	Total overhead (sum of lines 14 and 15)	823,506	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	823,506	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	814,957	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,686,673	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-2 | Date/Time Prepared: 11/22/2021 9:50 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	2.23	9,170	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.83	3,794	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.06	12,964		4	12,964	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)	4.06	12,964			12,964	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)	1,837,276	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	10,980	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,848,256	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.994059	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,655,284	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,655,284	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,655,284	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,645,450	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,482,726	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/22/2021 9:50 am
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,686,673	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	40,841	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,645,832	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	6,768	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	6,768	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	243.18	7.00

		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	257.93	8.00
9.00	Rate for Program covered visits (see instructions)	243.18	243.18	243.18	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	823	309	298	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	200,137	75,143	72,468	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	347,748		16.00
16.01	Total program charges (see instructions)(from contractor's records)		311,367		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		33,167		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		37,042		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.)		215,662		16.04
16.05	Total program cost (see instructions)	0	252,704		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,129		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		47,409		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		252,704		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,356		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		276,060		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)		276,060		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		153,127		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)		122,933		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: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-3 | Date/Time Prepared: 11/22/2021 9:50 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)	3,482,726	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	86,813	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	3,395,913	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	12,964	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)	12,964	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	261.95	7.00

		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	249.16	8.00
9.00	Rate for Program covered visits (see instructions)	261.95	261.95	249.16	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,900	951	877	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	497,705	249,114	218,513	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	965,332		16.00
16.01	Total program charges (see instructions)(from contractor's records)		767,810		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		43,758		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		55,015		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.)		661,737		16.04
16.05	Total program cost (see instructions)	0	716,752		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		83,146		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		128,181		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		716,752		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66,200		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		782,952		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)		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)		782,952		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		498,741		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)		284,211		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: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-4 | Date/Time Prepared: 11/22/2021 9:50 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)	660,628	660,628	660,628	660,628	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000166	0.000541	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	110	357	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,606	10,035	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,716	10,392	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	871,716	871,716	871,716	871,716	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	814,957	814,957	814,957	814,957	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012293	0.011921	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,018	9,715	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,734	20,107	0	0	10.00
11.00	Total number of injections/infusions (from your records)	75	244	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	276.45	82.41	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	35	166	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)	9,676	13,680	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)		40,841			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)		23,356			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1307 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-4

Component CCN: 15-3994 | Date/Time Prepared: 11/22/2021 9:50 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)	1,459,804	1,459,804	1,459,804	1,459,804	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000251	0.000434	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	366	634	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	29,522	15,275	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	29,888	15,909	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,837,276	1,837,276	1,837,276	1,837,276	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,645,450	1,645,450	1,645,450	1,645,450	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.016268	0.008659	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26,768	14,248	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	56,656	30,157	0	0	10.00
11.00	Total number of injections/infusions (from your records)	230	398	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.33	75.77	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	198	230	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)	48,773	17,427	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)		86,813			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)		66,200			16.00

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

Provider CCN: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-5 | Date/Time Prepared: 11/22/2021 9:50 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		153,127	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)		153,127	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		122,933	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		276,060	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: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2020 To 06/30/2021 | Worksheet M-5 | Date/Time Prepared: 11/22/2021 9:50 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		498,741	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)		498,741	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		284,211	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		782,952	7.00

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