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: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/19/2022 5:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/19/2022 Time: 5:14 pm
2. [ ] Manually prepared cost report
3. [1] 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. [5] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	16,275	272,728	0	41,016	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		213,043		0	10.00
10.01	RURAL HEALTH CLINIC II	0		117,618		0	10.01
10.02	RURAL HEALTH CLINIC III	0		19,357		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		42,715		0	10.03
200.00	Total	0	16,275	665,461	0	41,016	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/19/2022 5:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	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	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	PULASKI MEMORIAL RHC - KNOX MEDICAL	158554	99915		07/06/2020	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2020	09/30/2021	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/19/2022 5:14 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 9/19/2022 5:14 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	180,938	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

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

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

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

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

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

		Part A	Part B	Title V	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/19/2022 5:14 pm

		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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 9/19/2022 5:14 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/18/2022	Y	01/18/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part II Date/Time Prepared: 9/19/2022 5:14 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	MICHAEL		ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRINI@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/19/2022 5:14 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 9/19/2022 5:14 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	33,864.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	33,864.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	33,864.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	600	55	1,411			1.00
2.00	HMO and other (see instructions)	234	197				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	401	0	401			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	143			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,001	55	1,955			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	158			13.00
14.00	Total (see instructions)	1,001	55	2,113	0.00	181.69	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,044	261	19,213	0.00	50.92	26.00
26.01	RURAL HEALTH CLINIC II	1,791	27	4,127	0.00	5.27	26.01
26.02	RURAL HEALTH CLINIC III	329	12	967	0.00	2.85	26.02
26.03	RURAL HEALTH CLINIC IV	1,078	5	3,197	0.00	5.33	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	246.06	27.00
28.00	Observation Bed Days		34	371			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	9			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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

	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	163	18	428	1.00
2.00	HMO and other (see instructions)			50	78		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	163	18	428	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 9/19/2022 5:14 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	540 HOSPITAL DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC	IN	46996-	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PULASKI				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	17:30	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			NORTH LANE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON		IN	46366-1226	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PULASKI				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 E MONTGOMERY STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRANCESVILLE		IN	47946-8087	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	09:00	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

			County				
			4.00				
2.00	City, State, ZIP Code, County		PULASKI				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	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC III	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-8 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2 S. PEARL STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNOX		IN	46534	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	19:00	08:00	11.00

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County						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	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC IV	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-10 | Date/Time Prepared: 9/19/2022 5:14 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.518042	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	899,776	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	235,830	5.00
6.00	Medicaid charges	10,666,898	6.00
7.00	Medicaid cost (line 1 times line 6)	5,525,901	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)	4,390,295	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)	4,390,295	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)	101,501	0	101,501	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	52,582	0	52,582	21.00
22.00	Payments received from patients for amounts previously written off as charity care	150,791	0	150,791	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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)	1,039,738	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	289,003	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	444,620	27.01
28.00	Non-Medicare bad debt expense (see instructions)	595,118	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	463,913	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	463,913	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,854,208	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,538,350	1,538,350	41,588	1,579,938	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,314,311	6,314,311	0	6,314,311	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,941,010	3,325,904	6,266,914	98,670	6,365,584	5.00
7.00	00700	OPERATION OF PLANT	402,698	547,897	950,595	0	950,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,052	48,015	60,067	0	60,067	8.00
9.00	00900	HOUSEKEEPING	203,895	123,858	327,753	0	327,753	9.00
10.00	01000	DIETARY	213,016	169,597	382,613	0	382,613	10.00
13.00	01300	NURSING ADMINISTRATION	426,481	397,825	824,306	0	824,306	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,105	38,433	60,538	0	60,538	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	334,050	48,937	382,987	0	382,987	16.00
17.00	01700	SOCIAL SERVICE	36,402	43	36,445	0	36,445	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,065,383	176,336	2,241,719	179,307	2,421,026	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	16,233	3,848	20,081	37,430	57,511	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	600,453	106,536	706,989	1,061,623	1,768,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,231	20,117	68,348	46,788	115,136	52.00
53.00	05300	ANESTHESIOLOGY	0	509,937	509,937	0	509,937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	885,995	528,826	1,414,821	0	1,414,821	54.00
60.00	06000	LABORATORY	719,536	734,227	1,453,763	0	1,453,763	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	33,582	33,582	0	33,582	63.00
65.00	06500	RESPIRATORY THERAPY	354,467	40,530	394,997	0	394,997	65.00
66.00	06600	PHYSICAL THERAPY	950,925	64,684	1,015,609	0	1,015,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,602	390	140,992	0	140,992	67.00
68.00	06800	SPEECH PATHOLOGY	75,583	3,202	78,785	0	78,785	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,988	17,988	0	17,988	69.00
69.01	06901	CARDIAC REHABILITATION	71,200	2,893	74,093	0	74,093	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	553,658	553,658	-216,524	337,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	216,524	216,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,196	2,073,994	2,120,190	0	2,120,190	73.00
76.00	03020	ONCOLOGY	118,989	38,880	157,869	0	157,869	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,391,570	363,488	5,755,058	-1,548,098	4,206,960	88.00
88.01	08801	RURAL HEALTH CLINIC II	710,136	101,416	811,552	57,216	868,768	88.01
88.02	08802	RURAL HEALTH CLINIC III	204,974	29,876	234,850	29,975	264,825	88.02
88.03	08803	RURAL HEALTH CLINIC IV	561,594	67,866	629,460	26,402	655,862	88.03
90.00	09000	CLINIC	51,813	193,063	244,876	0	244,876	90.00
91.00	09100	EMERGENCY	1,060,793	1,342,119	2,402,912	0	2,402,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,666,382	19,560,626	38,227,008	30,901	38,257,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	286,243	53,741	339,984	1,441	341,425	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	84,687	130,929	215,616	-32,342	183,274	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,037,312	19,745,296	38,782,608	0	38,782,608	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 9/19/2022 5:14 pm

		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	-17,033	1,562,905		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,314,311		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-912,827	5,452,757		5.00
7.00	00700	OPERATION OF PLANT	-278	950,317		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,067		8.00
9.00	00900	HOUSEKEEPING	0	327,753		9.00
10.00	01000	DIETARY	-61,852	320,761		10.00
13.00	01300	NURSING ADMINISTRATION	0	824,306		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-9,084	51,454		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,516	378,471		16.00
17.00	01700	SOCIAL SERVICE	0	36,445		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-512,167	1,908,859		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	57,511		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,338,278	430,334		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	115,136		52.00
53.00	05300	ANESTHESIOLOGY	-500,000	9,937		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,414,821		54.00
60.00	06000	LABORATORY	0	1,453,763		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	33,582		63.00
65.00	06500	RESPIRATORY THERAPY	0	394,997		65.00
66.00	06600	PHYSICAL THERAPY	0	1,015,609		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,992		67.00
68.00	06800	SPEECH PATHOLOGY	0	78,785		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,503	13,485		69.00
69.01	06901	CARDIAC REHABILITATION	0	74,093		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	337,134		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	216,524		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,361	2,108,829		73.00
76.00	03020	ONCOLOGY	-30,000	127,869		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,206,960		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	868,768		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	264,825		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	655,862		88.03
90.00	09000	CLINIC	0	244,876		90.00
91.00	09100	EMERGENCY	0	2,402,912		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,401,899	34,856,010		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	341,425		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	183,274		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,401,899	35,380,709		200.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/19/2022 5:14 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	41,588		1.00
	0		0	41,588		
	B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	12,703	19,639		1.00
	0		12,703	19,639		
	C - IMPLANATABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	216,524		1.00
	0		0	216,524		
	D - PHYSICIAN SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	263,525	0		1.00
2.00	OPERATING ROOM	50.00	1,061,623	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	23,810	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	21,578	0		4.00
5.00	RURAL HEALTH CLINIC IV	88.03	27,716	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,441	0		6.00
	0		1,399,693	0		
	G - PATIENT ACCOUNTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	107,916	0		1.00
	0		107,916	0		
	H - RHC DEPT 175 RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01		35,839		1.00
2.00	RURAL HEALTH CLINIC III	88.02		8,397		2.00
3.00	RURAL HEALTH CLINIC IV	88.03		27,763		3.00
	0		0	71,999		
	I - RN SALARIES RECLASS					
1.00	NURSERY	43.00	37,430	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	46,788	0		2.00
	0		84,218	0		
500.00	Grand Total: Increases		1,604,530	349,750		500.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 9/19/2022 5:14 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	41,588	12		1.00
	0		0	41,588			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	12,703	19,639	0		1.00
	0		12,703	19,639			
	C - IMPLANATABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	216,524	0		1.00
	0		0	216,524			
	D - PHYSICIAN SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	1,368,183	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	2,433	0	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	29,077	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		1,399,693	0			
	G - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	107,916	0	0		1.00
	0		107,916	0			
	H - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	71,999	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	71,999			
	I - RN SALARIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	84,218	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		84,218	0			
500.00	Grand Total: Decreases		1,604,530	349,750			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	0	0	0	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	0	0	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	7,449,386	2,641,104	0	2,641,104	0	5.00
6.00	Movable Equipment	9,029,066	748,156	0	748,156	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,546,664	3,389,260	0	3,389,260	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,546,664	3,389,260	0	3,389,260	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	195,525	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	10,090,490	0	5.00
6.00	Movable Equipment	9,777,222	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,935,924	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,935,924	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 9/19/2022 5:14 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,538,350	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	1,538,350	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,538,350		1.00
3.00	Total (sum of lines 1-2)	0	1,538,350		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part III Date/Time Prepared: 9/19/2022 5:14 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	33,935,924	0	33,935,924	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	33,935,924	0	33,935,924	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,537,617	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,537,617	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-16,300	41,588	0	0	1,562,905	1.00
3.00	Total (sum of lines 1-2)	-16,300	41,588	0	0	1,562,905	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/19/2022 5:14 pm

	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)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,884,948			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		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 - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 9/19/2022 5:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVEST INC/UNRESTRIC- INT EXP	B	-16,300	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	OTHER SERVICES -OTHER REV	B	-17,484	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CAFETERIA VENDING - OTHER REV	B	-61,852	DIETARY	10.00	0	33.02
33.03	REBATES & REFUNDS - OTHER REV	B	-9,084	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	MEDICAL RECORDS FEES -OTHER REV	B	-4,516	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	EMPLOYEE RX PROGRAM -OTHER REV	B	-11,361	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.07	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	33.07
33.08	PHYSICIAN RECRUITMENT- ADMIN	A	-6,776	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING EXPENSE	A	-3,500	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CRNA	A	-500,000	ANESTHESIOLOGY	53.00	0	33.10
33.11	HAF EXPENSE	A	-885,067	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EHR DEPRECIATION ON 2012 PAYMENT	A	-733	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,401,899				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 9/19/2022 5:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	512,167	512,167	0	0	0	1.00
2.00	50.00	OPERATING ROOM	1,338,278	1,338,278	0	0	0	2.00
3.00	60.00	LABORATORY	660	0	660	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	4,503	4,503	0	0	0	4.00
5.00	76.00	ONCOLOGY	30,000	30,000	0	0	0	5.00
6.00	90.00	CLINIC	36,500	0	36,500	0	0	6.00
7.00	91.00	EMERGENCY	1,232,616	0	1,232,616	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			3,154,724	1,884,948	1,269,776		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.00	ONCOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	512,167		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,338,278		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,503		4.00
5.00	76.00	ONCOLOGY	0	0	0	30,000		5.00
6.00	90.00	CLINIC	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,884,948		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,562,905	1,562,905				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,314,311	27,419	6,341,730			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,452,757	303,902	1,019,893	6,776,552	6,776,552	5.00
7.00	00700	OPERATION OF PLANT	950,317	136,548	134,147	1,221,012	289,268	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,067	12,658	4,015	76,740	18,180	8.00
9.00	00900	HOUSEKEEPING	327,753	7,759	67,922	403,434	95,577	9.00
10.00	01000	DIETARY	320,761	62,933	70,960	454,654	107,711	10.00
13.00	01300	NURSING ADMINISTRATION	824,306	34,127	142,070	1,000,503	237,027	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,454	19,870	7,364	78,688	18,642	14.00
15.00	01500	PHARMACY	0	16,296	0	16,296	3,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	378,471	32,886	111,279	522,636	123,817	16.00
17.00	01700	SOCIAL SERVICE	36,445	0	12,126	48,571	11,507	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,908,859	183,964	747,753	2,840,576	672,955	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	57,511	3,385	17,876	78,772	18,662	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	430,334	111,526	553,672	1,095,532	259,540	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,136	13,731	31,653	160,520	38,028	52.00
53.00	05300	ANESTHESIOLOGY	9,937	652	0	10,589	2,509	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,414,821	101,265	295,144	1,811,230	429,095	54.00
60.00	06000	LABORATORY	1,453,763	29,206	239,693	1,722,662	408,112	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	33,582	1,283	0	34,865	8,260	63.00
65.00	06500	RESPIRATORY THERAPY	394,997	16,464	118,080	529,541	125,452	65.00
66.00	06600	PHYSICAL THERAPY	1,015,609	37,197	316,773	1,369,579	324,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,992	0	46,837	187,829	44,498	67.00
68.00	06800	SPEECH PATHOLOGY	78,785	0	25,178	103,963	24,630	68.00
69.00	06900	ELECTROCARDIOLOGY	13,485	0	0	13,485	3,195	69.00
69.01	06901	CARDIAC REHABILITATION	74,093	9,420	23,718	107,231	25,404	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	337,134	0	0	337,134	79,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	216,524	0	0	216,524	51,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,108,829	0	15,389	2,124,218	503,244	73.00
76.00	03020	ONCOLOGY	127,869	11,859	39,638	179,366	42,493	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,206,960	215,315	1,304,329	5,726,604	1,356,677	88.00
88.01	08801	RURAL HEALTH CLINIC II	868,768	0	243,682	1,112,450	263,548	88.01
88.02	08802	RURAL HEALTH CLINIC III	264,825	0	75,469	340,294	80,618	88.02
88.03	08803	RURAL HEALTH CLINIC IV	655,862	0	186,625	842,487	199,592	88.03
90.00	09000	CLINIC	244,876	38,164	17,260	300,300	71,143	90.00
91.00	09100	EMERGENCY	2,402,912	125,593	353,372	2,881,877	682,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,856,010	1,553,422	6,221,917	34,726,714	6,621,615	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,483	0	9,483	2,247	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341,425	0	95,834	437,259	103,590	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	183,274	0	23,979	207,253	49,100	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)	35,380,709	1,562,905	6,341,730	35,380,709	6,776,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,510,280					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,750	107,670				8.00
9.00	00900	HOUSEKEEPING	7,815	0	506,826			9.00
10.00	01000	DIETARY	63,389	0	22,214	647,968		10.00
13.00	01300	NURSING ADMINISTRATION	34,374	0	12,046	0	1,283,950	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,014	0	7,014	0	0	14.00
15.00	01500	PHARMACY	16,414	0	5,752	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,124	0	11,608	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	185,296	23,278	64,936	647,968	770,172	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,410	2,812	1,195	0	21,150	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	112,334	24,369	39,367	0	150,336	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,830	0	4,847	0	23,389	52.00
53.00	05300	ANESTHESIOLOGY	657	0	230	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,998	18,198	35,745	0	0	54.00
60.00	06000	LABORATORY	29,418	453	10,309	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,292	0	453	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,583	0	5,812	0	24,469	65.00
66.00	06600	PHYSICAL THERAPY	50,067	17,966	17,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	9,488	0	3,325	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	11,945	16	4,186	0	45,110	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	216,874	1,752	76,003	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	82,683	300	28,976	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	34,776	51	12,187	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	45,556	0	15,965	0	0	88.03
90.00	09000	CLINIC	38,440	0	13,471	0	20,718	90.00
91.00	09100	EMERGENCY	126,503	18,149	44,332	0	228,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,269,030	107,344	437,519	647,968	1,283,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,552	0	3,347	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	231,698	326	65,960	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,510,280	107,670	506,826	647,968	1,283,950	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	124,358					14.00
15.00	01500	PHARMACY	0	42,323				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	691,185			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	60,078		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	21,421	56,068	5,282,670	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,178	0	127,179	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	57,932	4,010	1,743,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,036	0	245,650	52.00
53.00	05300	ANESTHESIOLOGY	0	0	8,269	0	22,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	148,569	0	2,544,835	54.00
60.00	06000	LABORATORY	0	0	144,378	0	2,315,332	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,201	0	47,071	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,004	0	712,861	65.00
66.00	06600	PHYSICAL THERAPY	0	0	30,512	0	1,810,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,204	0	237,531	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,698	0	130,291	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6,177	0	22,857	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	2,279	0	147,727	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,578	0	24,526	0	554,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,780	0	3,763	0	283,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,323	94,050	0	2,763,835	73.00
76.00	03020	ONCOLOGY	0	0	4,124	0	287,240	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	48,859	0	7,426,769	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	7,743	0	1,495,700	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,934	0	469,860	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	5,435	0	1,109,035	88.03
90.00	09000	CLINIC	0	0	764	0	444,836	90.00
91.00	09100	EMERGENCY	0	0	54,129	0	4,036,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,358	42,323	691,185	60,078	34,260,894	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	24,629	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	838,833	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	256,353	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)	124,358	42,323	691,185	60,078	35,380,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 9/19/2022 5:14 pm

		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
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
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,282,670		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	127,179		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,743,420		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	245,650		52.00
53.00	05300	ANESTHESIOLOGY	0	22,254		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,544,835		54.00
60.00	06000	LABORATORY	0	2,315,332		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	47,071		63.00
65.00	06500	RESPIRATORY THERAPY	0	712,861		65.00
66.00	06600	PHYSICAL THERAPY	0	1,810,134		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	237,531		67.00
68.00	06800	SPEECH PATHOLOGY	0	130,291		68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,857		69.00
69.01	06901	CARDIAC REHABILITATION	0	147,727		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	554,108		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	283,363		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,763,835		73.00
76.00	03020	ONCOLOGY	0	287,240		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,426,769		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,495,700		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	469,860		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,109,035		88.03
90.00	09000	CLINIC	0	444,836		90.00
91.00	09100	EMERGENCY	0	4,036,336		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	34,260,894		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,629		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	838,833		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	256,353		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	35,380,709		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,419	27,419	27,419		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	303,902	303,902	4,409	308,311	5.00
7.00	00700	OPERATION OF PLANT	0	136,548	136,548	580	13,161	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,658	12,658	17	827	8.00
9.00	00900	HOUSEKEEPING	0	7,759	7,759	294	4,349	9.00
10.00	01000	DIETARY	0	62,933	62,933	307	4,901	10.00
13.00	01300	NURSING ADMINISTRATION	0	34,127	34,127	614	10,784	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,870	19,870	32	848	14.00
15.00	01500	PHARMACY	0	16,296	16,296	0	176	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,886	32,886	481	5,633	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	52	524	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	183,964	183,964	3,232	30,619	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,385	3,385	77	849	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,526	111,526	2,393	11,809	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,731	13,731	137	1,730	52.00
53.00	05300	ANESTHESIOLOGY	0	652	652	0	114	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,265	101,265	1,276	19,523	54.00
60.00	06000	LABORATORY	0	29,206	29,206	1,036	18,569	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,283	1,283	0	376	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,464	16,464	510	5,708	65.00
66.00	06600	PHYSICAL THERAPY	0	37,197	37,197	1,369	14,763	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	202	2,025	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	109	1,121	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	145	69.00
69.01	06901	CARDIAC REHABILITATION	0	9,420	9,420	103	1,156	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67	22,897	73.00
76.00	03020	ONCOLOGY	0	11,859	11,859	171	1,933	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	215,315	215,315	5,644	61,713	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,053	11,991	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	326	3,668	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	807	9,081	88.03
90.00	09000	CLINIC	0	38,164	38,164	75	3,237	90.00
91.00	09100	EMERGENCY	0	125,593	125,593	1,528	31,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,553,422	1,553,422	26,901	301,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,483	9,483	0	102	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	414	4,713	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	104	2,234	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,562,905	1,562,905	27,419	308,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	150,289					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,269	14,771				8.00
9.00	00900	HOUSEKEEPING	778	0	13,180			9.00
10.00	01000	DIETARY	6,308	0	578	75,027		10.00
13.00	01300	NURSING ADMINISTRATION	3,421	0	313	0	49,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,992	0	182	0	0	14.00
15.00	01500	PHARMACY	1,633	0	150	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,296	0	302	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,439	3,193	1,689	75,027	29,547	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	339	386	31	0	811	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,178	3,343	1,024	0	5,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,376	0	126	0	897	52.00
53.00	05300	ANESTHESIOLOGY	65	0	6	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,150	2,497	930	0	0	54.00
60.00	06000	LABORATORY	2,927	62	268	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	129	0	12	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,650	0	151	0	939	65.00
66.00	06600	PHYSICAL THERAPY	4,982	2,465	456	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	944	0	86	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,189	2	109	0	1,731	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,581	240	1,976	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,228	41	754	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,461	7	317	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,533	0	415	0	0	88.03
90.00	09000	CLINIC	3,825	0	350	0	795	90.00
91.00	09100	EMERGENCY	12,588	2,490	1,153	0	8,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,281	14,726	11,378	75,027	49,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	951	0	87	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,057	45	1,715	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	150,289	14,771	13,180	75,027	49,259	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	22,924					14.00
15.00	01500	PHARMACY	0	18,255				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	42,598			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	576		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,320	538	347,568	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	73	0	5,951	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,570	38	150,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	310	0	18,307	52.00
53.00	05300	ANESTHESIOLOGY	0	0	510	0	1,347	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,161	0	144,802	54.00
60.00	06000	LABORATORY	0	0	8,897	0	60,965	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	136	0	1,936	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	678	0	26,100	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,880	0	63,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	321	0	2,548	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	105	0	1,335	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	381	0	526	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	140	0	11,849	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,753	0	1,511	0	25,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,171	0	232	0	4,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,255	5,795	0	47,014	73.00
76.00	03020	ONCOLOGY	0	0	254	0	17,248	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,011	0	309,480	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	477	0	22,544	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	119	0	7,898	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	335	0	15,171	88.03
90.00	09000	CLINIC	0	0	47	0	46,493	90.00
91.00	09100	EMERGENCY	0	0	3,335	0	186,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,924	18,255	42,598	576	1,520,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	10,623	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	29,944	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	2,338	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)	22,924	18,255	42,598	576	1,562,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 9/19/2022 5:14 pm

		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
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
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	347,568		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	5,951		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	150,649		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,307		52.00
53.00	05300	ANESTHESIOLOGY	0	1,347		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,802		54.00
60.00	06000	LABORATORY	0	60,965		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,936		63.00
65.00	06500	RESPIRATORY THERAPY	0	26,100		65.00
66.00	06600	PHYSICAL THERAPY	0	63,112		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,548		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,335		68.00
69.00	06900	ELECTROCARDIOLOGY	0	526		69.00
69.01	06901	CARDIAC REHABILITATION	0	11,849		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,898		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,737		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,014		73.00
76.00	03020	ONCOLOGY	0	17,248		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	309,480		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	22,544		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,898		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	15,171		88.03
90.00	09000	CLINIC	0	46,493		90.00
91.00	09100	EMERGENCY	0	186,522		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,520,000		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,623		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,944		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	2,338		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	1,562,905		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	74,329					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,304	19,037,312				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,453	3,061,629	-6,776,552	28,604,157		5.00
7.00	00700	OPERATION OF PLANT	6,494	402,698	0	1,221,012	71,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	602	12,052	0	76,740	602	8.00
9.00	00900	HOUSEKEEPING	369	203,895	0	403,434	369	9.00
10.00	01000	DIETARY	2,993	213,016	0	454,654	2,993	10.00
13.00	01300	NURSING ADMINISTRATION	1,623	426,481	0	1,000,503	1,623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	945	22,105	0	78,688	945	14.00
15.00	01500	PHARMACY	775	0	0	16,296	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,564	334,050	0	522,636	1,564	16.00
17.00	01700	SOCIAL SERVICE	0	36,402	0	48,571	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,749	2,244,690	0	2,840,576	8,749	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	53,663	0	78,772	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,304	1,662,076	0	1,095,532	5,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653	95,019	0	160,520	653	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	10,589	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,816	885,995	0	1,811,230	4,816	54.00
60.00	06000	LABORATORY	1,389	719,536	0	1,722,662	1,389	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61	0	0	34,865	61	63.00
65.00	06500	RESPIRATORY THERAPY	783	354,467	0	529,541	783	65.00
66.00	06600	PHYSICAL THERAPY	1,769	950,925	0	1,369,579	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,602	0	187,829	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	75,583	0	103,963	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,485	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	71,200	0	107,231	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	337,134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	216,524	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,196	0	2,124,218	0	73.00
76.00	03020	ONCOLOGY	564	118,989	0	179,366	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,240	3,915,471	0	5,726,604	10,240	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	731,513	0	1,112,450	3,904	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	226,552	0	340,294	1,642	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	560,233	0	842,487	2,151	88.03
90.00	09000	CLINIC	1,815	51,813	0	300,300	1,815	90.00
91.00	09100	EMERGENCY	5,973	1,060,793	0	2,881,877	5,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,878	18,677,644	-6,776,552	27,950,162	59,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	9,483	451	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	287,684	0	437,259	10,940	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	71,984	0	207,253	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)	1,562,905	6,341,730		6,776,552	1,510,280	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.026854	0.333121		0.236908	21.179077	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		27,419		308,311	150,289	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001440		0.010779	2.107545	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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	117,392					8.00
9.00	00900	HOUSEKEEPING	0	68,286				9.00
10.00	01000	DIETARY	0	2,993	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	1,623	0	83,168		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	945	0	0	2,706,871	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,564	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,380	8,749	100	49,888	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,066	161	0	1,370	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,570	5,304	0	9,738	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	653	0	1,515	0	52.00
53.00	05300	ANESTHESIOLOGY	0	31	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,841	4,816	0	0	0	54.00
60.00	06000	LABORATORY	494	1,389	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	1,585	0	65.00
66.00	06600	PHYSICAL THERAPY	19,588	2,364	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,450,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	256,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	17	564	0	2,922	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,910	10,240	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	327	3,904	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	56	1,642	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,151	0	0	0	88.03
90.00	09000	CLINIC	0	1,815	0	1,342	0	90.00
91.00	09100	EMERGENCY	19,788	5,973	0	14,808	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,037	58,948	100	83,168	2,706,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	355	8,887	0	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
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)	107,670	506,826	647,968	1,283,950	124,358	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.917183	7.422107	6,479.680000	15.438029	0.045942	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,771	13,180	75,027	49,259	22,924	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.125826	0.193012	750.270000	0.592283	0.008469	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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 9/19/2022 5:14 pm

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,135,353			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,049,683	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	112,675	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,543,183	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	481,883	0		52.00
53.00	05300	ANESTHESIOLOGY	0	791,208	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,215,265	0		54.00
60.00	06000	LABORATORY	0	13,814,734	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	210,608	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,052,910	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,919,569	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	497,979	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	162,451	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	591,058	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	218,068	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,346,781	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	360,090	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	8,999,152	0		73.00
76.00	03020	ONCOLOGY	0	394,605	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	4,675,049	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	740,872	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	185,076	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	520,075	0		88.03
90.00	09000	CLINIC	0	73,106	0		90.00
91.00	09100	EMERGENCY	0	5,179,273	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	66,135,353	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	KNOX RHC	0	0	0		192.01
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)	42,323	691,185	60,078		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	423.230000	0.010451	6.075850		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,255	42,598	576		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	182.550000	0.000644	0.058252		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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,282,670		5,282,670	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	127,179		127,179	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,743,420		1,743,420	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	245,650		245,650	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,254		22,254	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,544,835		2,544,835	0	0	54.00
60.00	06000	LABORATORY	2,315,332		2,315,332	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	47,071		47,071	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	712,861	0	712,861	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,810,134	0	1,810,134	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,531	0	237,531	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,291	0	130,291	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,857		22,857	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	147,727		147,727	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	554,108		554,108	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	283,363		283,363	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,763,835		2,763,835	0	0	73.00
76.00	03020	ONCOLOGY	287,240		287,240	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,426,769		7,426,769	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,495,700		1,495,700	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	469,860		469,860	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,109,035		1,109,035	0	0	88.03
90.00	09000	CLINIC	444,836		444,836	0	0	90.00
91.00	09100	EMERGENCY	4,036,336		4,036,336	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	892,515		892,515		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,153,409	0	35,153,409	0	0	200.00
201.00		Less Observation Beds	892,515		892,515		0	201.00
202.00		Total (see instructions)	34,260,894	0	34,260,894	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,707,945		1,707,945			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	112,675		112,675			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	952,649	4,590,534	5,543,183	0.314516	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380,234	101,649	481,883	0.509771	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	123,564	667,644	791,208	0.028127	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,917	13,228,348	14,215,265	0.179021	0.000000	54.00
60.00	06000	LABORATORY	1,832,232	11,982,502	13,814,734	0.167599	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	91,568	119,040	210,608	0.223501	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	687,981	364,929	1,052,910	0.677039	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	359,317	2,560,252	2,919,569	0.620000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,562	348,417	497,979	0.476990	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,886	124,565	162,451	0.802033	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,983	566,075	591,058	0.038671	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	218,068	218,068	0.677435	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	825,049	1,521,732	2,346,781	0.236114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,478	182,612	360,090	0.786923	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,901,069	5,098,083	8,999,152	0.307122	0.000000	73.00
76.00	03020	ONCOLOGY	0	394,605	394,605	0.727918	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,675,049	4,675,049			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	740,872	740,872			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	185,076	185,076			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	520,075	520,075			88.03
90.00	09000	CLINIC	0	73,106	73,106	6.084808	0.000000	90.00
91.00	09100	EMERGENCY	233,037	4,946,236	5,179,273	0.779325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	341,738	341,738	2.611694	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,584,146	53,551,207	66,135,353			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,584,146	53,551,207	66,135,353			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,282,670		5,282,670	0	5,282,670	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	127,179		127,179	0	127,179	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,743,420		1,743,420	0	1,743,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	245,650		245,650	0	245,650	52.00
53.00	05300	ANESTHESIOLOGY	22,254		22,254	0	22,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,544,835		2,544,835	0	2,544,835	54.00
60.00	06000	LABORATORY	2,315,332		2,315,332	0	2,315,332	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	47,071		47,071	0	47,071	63.00
65.00	06500	RESPIRATORY THERAPY	712,861	0	712,861	0	712,861	65.00
66.00	06600	PHYSICAL THERAPY	1,810,134	0	1,810,134	0	1,810,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,531	0	237,531	0	237,531	67.00
68.00	06800	SPEECH PATHOLOGY	130,291	0	130,291	0	130,291	68.00
69.00	06900	ELECTROCARDIOLOGY	22,857		22,857	0	22,857	69.00
69.01	06901	CARDIAC REHABILITATION	147,727		147,727	0	147,727	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	554,108		554,108	0	554,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	283,363		283,363	0	283,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,763,835		2,763,835	0	2,763,835	73.00
76.00	03020	ONCOLOGY	287,240		287,240	0	287,240	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,426,769		7,426,769	0	7,426,769	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,495,700		1,495,700	0	1,495,700	88.01
88.02	08802	RURAL HEALTH CLINIC III	469,860		469,860	0	469,860	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,109,035		1,109,035	0	1,109,035	88.03
90.00	09000	CLINIC	444,836		444,836	0	444,836	90.00
91.00	09100	EMERGENCY	4,036,336		4,036,336	0	4,036,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	892,515		892,515		892,515	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,153,409	0	35,153,409	0	35,153,409	200.00
201.00		Less Observation Beds	892,515		892,515		892,515	201.00
202.00		Total (see instructions)	34,260,894	0	34,260,894	0	34,260,894	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,707,945		1,707,945			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	112,675		112,675			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	952,649	4,590,534	5,543,183	0.314516	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380,234	101,649	481,883	0.509771	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	123,564	667,644	791,208	0.028127	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,917	13,228,348	14,215,265	0.179021	0.000000	54.00
60.00	06000	LABORATORY	1,832,232	11,982,502	13,814,734	0.167599	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	91,568	119,040	210,608	0.223501	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	687,981	364,929	1,052,910	0.677039	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	359,317	2,560,252	2,919,569	0.620000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,562	348,417	497,979	0.476990	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,886	124,565	162,451	0.802033	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,983	566,075	591,058	0.038671	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	218,068	218,068	0.677435	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	825,049	1,521,732	2,346,781	0.236114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,478	182,612	360,090	0.786923	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,901,069	5,098,083	8,999,152	0.307122	0.000000	73.00
76.00	03020	ONCOLOGY	0	394,605	394,605	0.727918	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,675,049	4,675,049	1.588597	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	740,872	740,872	2.018837	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	185,076	185,076	2.538741	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	520,075	520,075	2.132452	0.000000	88.03
90.00	09000	CLINIC	0	73,106	73,106	6.084808	0.000000	90.00
91.00	09100	EMERGENCY	233,037	4,946,236	5,179,273	0.779325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	341,738	341,738	2.611694	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,584,146	53,551,207	66,135,353			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,584,146	53,551,207	66,135,353			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part II Date/Time Prepared: 9/19/2022 5:14 pm

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	150,649	5,543,183	0.027177	203,966	5,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,307	481,883	0.037991	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,347	791,208	0.001702	21,843	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,802	14,215,265	0.010186	293,858	2,993	54.00
60.00	06000	LABORATORY	60,965	13,814,734	0.004413	410,733	1,813	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,936	210,608	0.009192	27,263	251	63.00
65.00	06500	RESPIRATORY THERAPY	26,100	1,052,910	0.024788	329,312	8,163	65.00
66.00	06600	PHYSICAL THERAPY	63,112	2,919,569	0.021617	81,369	1,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,548	497,979	0.005117	36,070	185	67.00
68.00	06800	SPEECH PATHOLOGY	1,335	162,451	0.008218	7,330	60	68.00
69.00	06900	ELECTROCARDIOLOGY	526	591,058	0.000890	14,906	13	69.00
69.01	06901	CARDIAC REHABILITATION	11,849	218,068	0.054336	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,898	2,346,781	0.011036	162,138	1,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,737	360,090	0.013155	79,469	1,045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,014	8,999,152	0.005224	616,710	3,222	73.00
76.00	03020	ONCOLOGY	17,248	394,605	0.043710	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	309,480	4,675,049	0.066198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,544	740,872	0.030429	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,898	185,076	0.042674	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,171	520,075	0.029171	0	0	88.03
90.00	09000	CLINIC	46,493	73,106	0.635967	0	0	90.00
91.00	09100	EMERGENCY	186,522	5,179,273	0.036013	37,050	1,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	58,722	341,738	0.171833	0	0	92.00
200.00		Total (lines 50 through 199)	1,225,203	64,314,733		2,322,017	28,207	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	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
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/19/2022 5:14 pm

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	5,543,183	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	481,883	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	791,208	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,215,265	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,814,734	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	210,608	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,052,910	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,919,569	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	497,979	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	162,451	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	591,058	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	218,068	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,346,781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	360,090	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,999,152	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	394,605	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,675,049	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	740,872	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	185,076	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	520,075	0.000000	88.03
90.00	09000	CLINIC	0	0	0	73,106	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,179,273	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	341,738	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	64,314,733		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	203,966	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	21,843	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	293,858	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	410,733	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	27,263	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	329,312	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	81,369	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	36,070	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,330	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,906	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	162,138	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	79,469	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	616,710	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	37,050	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,322,017	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part V Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314516	0	1,273,710	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509771	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028127	0	179,164	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179021	0	3,981,138	0	0	54.00
60.00	06000	LABORATORY	0.167599	0	3,931,811	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.223501	0	54,155	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.677039	0	142,973	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.620000	0	829,621	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476990	0	133,895	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.802033	0	10,996	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038671	0	192,851	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.677435	0	87,757	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236114	0	390,573	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.786923	0	63,357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307122	0	2,428,552	1,648	0	73.00
76.00	03020	ONCOLOGY	0.727918	0	137,594	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	6.084808	0	58,975	0	0	90.00
91.00	09100	EMERGENCY	0.779325	0	1,285,741	10,553	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.611694	0	108,852	0	0	92.00
200.00		Subtotal (see instructions)		0	15,291,715	12,201	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	15,291,715	12,201	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part V Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	400,602	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	5,039	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	712,707	0		54.00
60.00	06000	LABORATORY	658,968	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,104	0		63.00
65.00	06500	RESPIRATORY THERAPY	96,798	0		65.00
66.00	06600	PHYSICAL THERAPY	514,365	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	63,867	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,819	0		68.00
69.00	06900	ELECTROCARDIOLOGY	7,458	0		69.00
69.01	06901	CARDIAC REHABILITATION	59,450	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,220	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,857	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	745,862	506		73.00
76.00	03020	ONCOLOGY	100,157	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	358,852	0		90.00
91.00	09100	EMERGENCY	1,002,010	8,224		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	284,288	0		92.00
200.00		Subtotal (see instructions)	5,173,423	8,730		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,173,423	8,730		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,326	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,782	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)	1,411	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	90	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)	311	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	32	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)	111	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	600	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)	401	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)	5,282,670	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)	6,942	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)	24,081	25.00
26.00	Total swing-bed cost (see instructions)	995,709	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,286,961	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)	4,286,961	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,405.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,443,420	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,443,420	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	808,467	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,251,887	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)	964,686	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	964,686	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)	371	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,405.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	892,515	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	347,568	5,282,670	0.065794	892,515	58,722	90.00
91.00	Nursing Program cost	0	5,282,670	0.000000	892,515	0	91.00
92.00	Allied health cost	0	5,282,670	0.000000	892,515	0	92.00
93.00	All other Medical Education	0	5,282,670	0.000000	892,515	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/19/2022 5:14 pm

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)	2,326	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,782	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)	1,411	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	401	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)	143	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	55	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)	158	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,282,670	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)	970,384	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,312,286	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)	4,312,286	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,419.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	133,095	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)	133,095	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/19/2022 5:14 pm

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)	127,179	158	804.93	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	71,716	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	204,811	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)	371	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,419.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	897,787	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 9/19/2022 5:14 pm

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	347,568	5,282,670	0.065794	897,787	59,069	90.00
91.00	Nursing Program cost	0	5,282,670	0.000000	897,787	0	91.00
92.00	Allied health cost	0	5,282,670	0.000000	897,787	0	92.00
93.00	All other Medical Education	0	5,282,670	0.000000	897,787	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 9/19/2022 5:14 pm

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		622,837		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314516	203,966	64,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509771	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028127	21,843	614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179021	293,858	52,607	54.00
60.00	06000	LABORATORY	0.167599	410,733	68,838	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.223501	27,263	6,093	63.00
65.00	06500	RESPIRATORY THERAPY	0.677039	329,312	222,957	65.00
66.00	06600	PHYSICAL THERAPY	0.620000	81,369	50,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476990	36,070	17,205	67.00
68.00	06800	SPEECH PATHOLOGY	0.802033	7,330	5,879	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038671	14,906	576	69.00
69.01	06901	CARDIAC REHABILITATION	0.677435	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236114	162,138	38,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.786923	79,469	62,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307122	616,710	189,405	73.00
76.00	03020	ONCOLOGY	0.727918	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	6.084808	0	0	90.00
91.00	09100	EMERGENCY	0.779325	37,050	28,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.611694	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,322,017	808,467	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)		2,322,017		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314516	2,146	675	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509771	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028127	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179021	21,860	3,913	54.00
60.00	06000	LABORATORY	0.167599	44,510	7,460	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.223501	2,574	575	63.00
65.00	06500	RESPIRATORY THERAPY	0.677039	78,461	53,121	65.00
66.00	06600	PHYSICAL THERAPY	0.620000	121,792	75,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476990	59,962	28,601	67.00
68.00	06800	SPEECH PATHOLOGY	0.802033	4,019	3,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038671	197	8	69.00
69.01	06901	CARDIAC REHABILITATION	0.677435	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236114	25,397	5,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.786923	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307122	150,156	46,116	73.00
76.00	03020	ONCOLOGY	0.727918	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	6.084808	0	0	90.00
91.00	09100	EMERGENCY	0.779325	185	144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.611694	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		511,259	225,344	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)		511,259		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 9/19/2022 5:14 pm

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		32,374		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		13,494		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314516	32,479	10,215	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509771	28,190	14,370	52.00
53.00	05300	ANESTHESIOLOGY	0.028127	5,588	157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179021	12,206	2,185	54.00
60.00	06000	LABORATORY	0.167599	44,020	7,378	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.223501	1,797	402	63.00
65.00	06500	RESPIRATORY THERAPY	0.677039	4,859	3,290	65.00
66.00	06600	PHYSICAL THERAPY	0.620000	2,015	1,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476990	559	267	67.00
68.00	06800	SPEECH PATHOLOGY	0.802033	2,157	1,730	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038671	194	8	69.00
69.01	06901	CARDIAC REHABILITATION	0.677435	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236114	28,250	6,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.786923	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307122	54,831	16,840	73.00
76.00	03020	ONCOLOGY	0.727918	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.588597	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.018837	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.538741	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.132452	0	0	88.03
90.00	09000	CLINIC	6.084808	0	0	90.00
91.00	09100	EMERGENCY	0.779325	8,925	6,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.611694	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		226,070	71,716	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)		226,070		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E Part B Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,182,153	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,182,153	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,233,975	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)	61,705	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,295,872	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)	2,876,398	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)	2,876,398	30.00
31.00	Primary payer payments	1,008	31.00
32.00	Subtotal (line 30 minus line 31)	2,875,390	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)	419,581	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	272,728	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	220,348	36.00
37.00	Subtotal (see instructions)	3,148,118	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)	3,148,118	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,875,390	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)	272,728	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,635,282		2,622,732	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	06/30/2021	362,600	06/30/2021	446,300	3.01
3.02		02/28/2022	82,748		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	02/28/2022	193,642	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)		445,348		252,658	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,080,630		2,875,390	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		16,275		272,728	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,096,905		3,148,118	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: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-1 Part I | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		888,041		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	06/30/2021	201,300		0	3.01
3.02		02/28/2022	102,395		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)		303,695		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,191,736		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,191,736		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: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-2 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	974,333	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)	227,597	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	401	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,201,930	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,201,930	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	2,574	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,199,356	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,620	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,191,736	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)	1,191,736	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,191,736	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)	0	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 - SWING BEDS | Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-2 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XIX | Swing Beds - SNF | PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	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)	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		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: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,251,887	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,251,887	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,274,406	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,274,406	19.00
20.00	Deductibles (exclude professional component)	193,776	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,080,630	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,080,630	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25,039	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,275	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,224	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,096,905	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,096,905	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	2,080,630	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)	16,275	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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-3 Part VII | Date/Time Prepared: 9/19/2022 5:14 pm

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	204,811		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)	204,811	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)	204,811	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	45,868		8.00
9.00	Ancillary service charges	226,070	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)	271,938	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)	271,938	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	67,127	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)	204,811	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)	204,811	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)	204,811	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)	204,811	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	204,811	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)	204,811	0	40.00
41.00	Interim payments	163,795	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	41,016	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: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G | Date/Time Prepared: 9/19/2022 5:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,797,332	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	11,565,908	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,329,879	0	0	0	6.00
7.00	Inventory	674,195	0	0	0	7.00
8.00	Prepaid expenses	31,698	0	0	0	8.00
9.00	Other current assets	3,750,238	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,489,492	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,525	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-420,317	0	0	0	14.00
15.00	Buildings	13,253,038	0	0	0	15.00
16.00	Accumulated depreciation	-8,763,421	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-195,033	0	0	0	18.00
19.00	Fixed equipment	7,468,798	0	0	0	19.00
20.00	Accumulated depreciation	-6,522,342	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,398,916	0	0	0	23.00
24.00	Accumulated depreciation	-8,744,297	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)	9,290,516	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	11,011,742	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,011,742	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,791,750	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,038,869	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,976,090	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	779,827	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,011,088	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,805,874	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,142,428	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-182,913	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,959,515	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,765,389	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,026,361				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,026,361	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,791,750	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-1 | Date/Time Prepared: 9/19/2022 5:14 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,146,668		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		879,693				2.00
3.00	Total (sum of line 1 and line 2)		23,026,361		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,026,361		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,026,361		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/19/2022 5:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,934,863		1,934,863	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)	1,934,863		1,934,863	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,934,863		1,934,863	17.00
18.00	Ancillary services	10,223,574	42,261,727	52,485,301	18.00
19.00	Outpatient services	233,037	5,361,080	5,594,117	19.00
20.00	RURAL HEALTH CLINIC	0	4,675,049	4,675,049	20.00
20.01	RURAL HEALTH CLINIC II	0	740,872	740,872	20.01
20.02	RURAL HEALTH CLINIC III	0	185,076	185,076	20.02
20.03	RURAL HEALTH CLINIC IV	0	520,075	520,075	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON-PROVIDER BASED	0	120,447	120,447	27.00
27.01	PHYSICIAN FEES	317,969	1,243	319,212	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,709,443	53,865,569	66,575,012	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,782,608		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)		38,782,608		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1305	Period: From 10/01/2020 To 09/30/2021	Worksheet G-3 Date/Time Prepared: 9/19/2022 5:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,575,012	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,341,565	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,233,447	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,782,608	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,549,161	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,346,357	24.00
24.01	RENTAL INCOME	23,299	24.01
24.02	NON OPERATING	95,295	24.02
24.50	COVID-19 PHE Funding	-36,097	24.50
25.00	Total other income (sum of lines 6-24)	6,428,854	25.00
26.00	Total (line 5 plus line 25)	879,693	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)	879,693	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

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	2,932,481	22,214	2,954,695	-1,351,293	1,603,402	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	985,934	41,070	1,027,004	-132,389	894,615	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	232,607	0	232,607	0	232,607	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	-42,037	-42,037	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	618,508	0	618,508	0	618,508	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,769,530	63,284	4,832,814	-1,525,719	3,307,095	10.00
11.00	Physician Services Under Agreement	0	0	0	-25,962	-25,962	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	-25,962	-25,962	14.00
15.00	Medical Supplies	0	42,822	42,822	-8,280	34,542	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42,822	42,822	-8,280	34,542	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,769,530	106,106	4,875,636	-1,559,961	3,315,675	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	157,536	157,536	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	157,536	157,536	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	104,151	104,151	-33,753	70,398	29.00
30.00	Administrative Costs	622,040	153,231	775,271	-111,920	663,351	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	622,040	257,382	879,422	-145,673	733,749	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,391,570	363,488	5,755,058	-1,548,098	4,206,960	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,603,402		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	894,615		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	232,607		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	-42,037		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	618,508		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,307,095		10.00
11.00	Physician Services Under Agreement	0	-25,962		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	-25,962		14.00
15.00	Medical Supplies	0	34,542		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	34,542		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,315,675		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	157,536		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	157,536		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	70,398		29.00
30.00	Administrative Costs	0	663,351		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	733,749		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,206,960		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

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	433,198	29,714	462,912	21,377	484,289	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	72,150	6,129	78,279	0	78,279	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	94,766	0	94,766	0	94,766	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	13,999	0	13,999	0	13,999	9.00
10.00	Subtotal (sum of lines 1 through 9)	614,113	35,843	649,956	21,377	671,333	10.00
11.00	Physician Services Under Agreement	0	0	0	12,923	12,923	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	12,923	12,923	14.00
15.00	Medical Supplies	0	16,167	16,167	4,122	20,289	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,167	16,167	4,122	20,289	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	614,113	52,010	666,123	38,422	704,545	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	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	34,242	34,242	16,801	51,043	29.00
30.00	Administrative Costs	96,023	15,164	111,187	1,993	113,180	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,023	49,406	145,429	18,794	164,223	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	710,136	101,416	811,552	57,216	868,768	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	484,289		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	78,279		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	94,766		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	13,999		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	671,333		10.00
11.00	Physician Services Under Agreement	0	12,923		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	12,923		14.00
15.00	Medical Supplies	0	20,289		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,289		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	704,545		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	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	51,043		29.00
30.00	Administrative Costs	0	113,180		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	164,223		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	868,768		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	21,578	21,578	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	123,653	10,214	133,867	-21,108	112,759	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	52,979	0	52,979	0	52,979	9.00
10.00	Subtotal (sum of lines 1 through 9)	176,632	10,214	186,846	470	187,316	10.00
11.00	Physician Services Under Agreement	0	0	0	3,028	3,028	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	3,028	3,028	14.00
15.00	Medical Supplies	0	4,348	4,348	966	5,314	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,348	4,348	966	5,314	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	176,632	14,562	191,194	4,464	195,658	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	21,108	21,108	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	21,108	21,108	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,945	7,945	3,937	11,882	29.00
30.00	Administrative Costs	28,342	7,369	35,711	466	36,177	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	28,342	15,314	43,656	4,403	48,059	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	204,974	29,876	234,850	29,975	264,825	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	21,578		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	112,759		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	52,979		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	187,316		10.00
11.00	Physician Services Under Agreement	0	3,028		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	3,028		14.00
15.00	Medical Supplies	0	5,314		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,314		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	195,658		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	21,108		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	21,108		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	11,882		29.00
30.00	Administrative Costs	0	36,177		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	48,059		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	264,825		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	317,210	15,000	332,210	-43,012	289,198	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	123,394	10,214	133,608	-16,202	117,406	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	70,384	0	70,384	0	70,384	9.00
10.00	Subtotal (sum of lines 1 through 9)	510,988	25,214	536,202	-59,214	476,988	10.00
11.00	Physician Services Under Agreement	0	0	0	10,011	10,011	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	10,011	10,011	14.00
15.00	Medical Supplies	0	0	0	3,193	3,193	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	3,193	3,193	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	510,988	25,214	536,202	-46,010	490,192	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	57,852	57,852	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	57,852	57,852	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	33,282	33,282	13,015	46,297	29.00
30.00	Administrative Costs	50,606	9,370	59,976	1,545	61,521	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	50,606	42,652	93,258	14,560	107,818	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	561,594	67,866	629,460	26,402	655,862	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-1 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	289,198		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	117,406		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	70,384		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	476,988		10.00
11.00	Physician Services Under Agreement	0	10,011		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	10,011		14.00
15.00	Medical Supplies	0	3,193		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,193		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	490,192		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	57,852		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	57,852		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	46,297		29.00
30.00	Administrative Costs	0	61,521		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	107,818		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	655,862		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-2 | Date/Time Prepared: 9/19/2022 5:14 pm

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	4.59	12,165	1	5		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	3.71	6,530	1	4		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.30	18,695		9	18,695	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	0.80	518			518	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)	9.10	19,213			19,213	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,315,675	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					157,536	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,473,211	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.954643	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					733,749	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,219,809	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,953,558	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,953,558	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,774,236	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,089,911	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 Component CCN: 15-8527

Period: From 10/01/2020 To 09/30/2021

Worksheet M-2 Date/Time Prepared: 9/19/2022 5:14 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.79	1,995	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.26	2,132	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.05	4,127		3	4,127	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)	3.05	4,127			4,127	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)					704,545	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					704,545	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					164,223	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					626,932	15.00
16.00	Total overhead (sum of lines 14 and 15)					791,155	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					791,155	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					791,155	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,495,700	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-2 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	59	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.59	908	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.63	967		1	967	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.63	967			967	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)					195,658	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					21,108	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					216,766	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.902623	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					48,059	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					205,035	15.00
16.00	Total overhead (sum of lines 14 and 15)					253,094	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					253,094	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					228,448	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					424,106	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-2 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.77	1,841	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.76	1,356	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.53	3,197		2	3,197	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.53	3,197			3,197	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)					490,192	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					57,852	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					548,044	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.894439	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					107,818	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					453,173	15.00
16.00	Total overhead (sum of lines 14 and 15)					560,991	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					560,991	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					501,772	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					991,964	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	7,089,911	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	144,641	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	6,945,270	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	19,213	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)	19,213	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	361.49	7.00

		Calculation of Limit (1)			
		Rate Period 1 (10/01/2020 through 12/31/2020)	Rate Period 2 (01/01/2021 through 03/31/2021)	Rate Period 3 (04/01/2021 through 09/30/2021)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	232.77	8.00
9.00	Rate for Program covered visits (see instructions)	361.49	361.49	232.77	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,254	1,135	2,636	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	453,308	410,291	613,582	11.00
12.00	Program covered visits for mental health services (from contractor records)	3	4	12	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,084	1,446	2,793	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,084	1,446	2,793	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	1,482,504		16.00
16.01	Total program charges (see instructions)(from contractor's records)		667,284		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		34,443		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		76,522		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.)		1,058,967		16.04
16.05	Total program cost (see instructions)	0	1,135,489		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		82,273		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		110,114		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,135,489		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		53,398		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,188,887		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)		1,188,887		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		975,844		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)		213,043		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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	RHC II	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				1,495,700	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				65,157	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				1,430,543	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				4,127	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				0	5.00
6.00	Total adjusted visits (line 4 plus line 5)				4,127	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				346.63	7.00
		Calculation of Limit (1)				
		Rate Period 1 (10/01/2020 through 12/31/2020)	Rate Period 2 (01/01/2021 through 03/31/2021)	Rate Period 3 (04/01/2021 through 09/30/2021)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	188.36		8.00
9.00	Rate for Program covered visits (see instructions)	346.63	346.63	188.36		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	375	413	1,003		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	129,986	143,158	188,925		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	462,069			16.00
16.01	Total program charges (see instructions)(from contractor's records)		215,954			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,014			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,265			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.)		317,026			16.04
16.05	Total program cost (see instructions)	0	351,291			16.05
17.00	Primary payer amounts		0			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,522			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,684			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		351,291			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,665			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		374,956			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)		374,956			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		257,338			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)		117,618			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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	RHC III	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				424,106	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				18,230	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				405,876	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				967	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)				967	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				419.73	7.00
		Calculation of Limit (1)				
		Rate Period 1 (10/01/2020 through 12/31/2020)	Rate Period 2 (01/01/2021 through 03/31/2021)	Rate Period 3 (04/01/2021 through 09/30/2021)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	306.89		8.00
9.00	Rate for Program covered visits (see instructions)	419.73	419.73	306.89		9.00
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	87	64	178		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	36,517	26,863	54,626		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	118,006			16.00
16.01	Total program charges (see instructions)(from contractor's records)		41,888			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,959			16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		22,422			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.)		71,721			16.04
16.05	Total program cost (see instructions)	0	94,143			16.05
17.00	Primary payer amounts		0			17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,933			18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,599			19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		94,143			20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,210			21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		106,353			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)		106,353			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		86,996			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)		19,357			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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 9/19/2022 5:14 pm
	Title XVIII	RHC IV	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	991,964	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	9,813	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	982,151	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	3,197	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	3,197	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	307.21	7.00

		Calculation of Limit (1)			
		Rate Period 1 (10/01/2020 through 12/31/2020)	Rate Period 2 (01/01/2021 through 03/31/2021)	Rate Period 3 (04/01/2021 through 09/30/2021)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	203.35	8.00
9.00	Rate for Program covered visits (see instructions)	307.21	307.21	203.35	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	265	244	569	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	81,411	74,959	115,706	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	272,076		16.00
16.01	Total program charges (see instructions)(from contractor's records)		134,643		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,276		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,661		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.)		193,901		16.04
16.05	Total program cost (see instructions)	0	204,562		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,039		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,066		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		204,562		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,744		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		208,306		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)		208,306		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		165,591		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		42,715		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: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-4 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,307,095	3,307,095	3,307,095	3,307,095	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000577	0.001912	0.000239	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,908	6,323	790	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	30,128	28,494	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	32,036	34,817	790	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,315,675	3,315,675	3,315,675	3,315,675	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,774,236	3,774,236	3,774,236	3,774,236	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009662	0.010501	0.000238	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	36,467	39,633	898	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	68,503	74,450	1,688	0	10.00
11.00	Total number of injections/infusions (from your records)	181	600	75	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	378.47	124.08	22.51	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	49	274	24	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			14	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)	18,545	33,998	855	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)		144,641			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)		53,398			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-4 | Date/Time Prepared: 9/19/2022 5:14 pm

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)	671,333	671,333	671,333	671,333	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002032	0.006681	0.000584	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,364	4,485	392	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,260	11,191	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,624	15,676	392	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	704,545	704,545	704,545	704,545	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	791,155	791,155	791,155	791,155	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.020757	0.022250	0.000556	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16,422	17,603	440	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,046	33,279	832	0	10.00
11.00	Total number of injections/infusions (from your records)	80	263	23	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	388.08	126.54	36.17	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	28	98	9	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			2	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)	10,866	12,401	398	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)		65,157			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)		23,665			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-4 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	187,316	187,316	187,316	187,316	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002650	0.003886	0.000088	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	496	728	16	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,681	2,489	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,177	3,217	16	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	195,658	195,658	195,658	195,658	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	228,448	228,448	228,448	228,448	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026459	0.016442	0.000082	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,045	3,756	19	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11,222	6,973	35	0	10.00
11.00	Total number of injections/infusions (from your records)	30	44	1	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	374.07	158.48	35.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	14	44	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,237	6,973	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)		18,230			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)		12,210			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-4

Component CCN: 15-8554 | Date/Time Prepared: 9/19/2022 5:14 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	476,988	476,988	476,988	476,988	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000183	0.002961	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	87	1,412	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,168	2,182	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,255	3,594	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490,192	490,192	490,192	490,192	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	501,772	501,772	501,772	501,772	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002560	0.007332	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,285	3,679	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,540	7,273	0	0	10.00
11.00	Total number of injections/infusions (from your records)	6	97	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	423.33	74.98	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	33	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)	1,270	2,474	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)		9,813			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)		3,744			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		883,789	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/28/2022	92,055	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)		92,055	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		975,844	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		213,043	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,188,887	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: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2020 To 09/30/2021 | Worksheet M-5 | Date/Time Prepared: 9/19/2022 5:14 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		246,063	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/28/2022	11,275	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)		11,275	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		257,338	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		117,618	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		374,956	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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 9/19/2022 5:14 pm

		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		72,184	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/28/2022	14,812	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)		14,812	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		86,996	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		19,357	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		106,353	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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 9/19/2022 5:14 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		173,241	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		02/28/2022	7,650	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)		-7,650	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		165,591	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		42,715	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		208,306	7.00

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