

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet S
Parts I-III
Date/Time Prepared:
1/31/2021 9:21 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/31/2021	Time: 9:21 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPHS HOSPITAL (14-0145) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	102,417	43,203	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-342	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		467,498		0	10.00
200.00	Total	0	102,075	510,701	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0145		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/31/2021 9:21 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 9515 HOLY CROSS LANE			PO Box:				1.00	
2.00	City: BREESE			State: IL		Zip Code: 62230		County: CLINTON	
		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			ST. JOSEPHS HOSPITAL	140145	41180	1	07/01/1966	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			ST. JOSEPHS HOSPITAL	14U145	41180		05/18/2019	N
8.00	Swing Beds - NF							P	N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC			ST. JOSEPH'S HOSPITAL RHC	148503	41180		01/01/2009	N
16.00	Hospital-Based Health Clinic - FQHC							O	N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						1		
							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.					Y	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)					Y	Y		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		22.03
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.					1	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 days	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.			263	125	0	0	512	61

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0145		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/31/2021 9:21 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			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)					Y	Y		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. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		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

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To 06/30/2020Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS 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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			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)				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)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				N		112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0115.00
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.				2		118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	69,842		0		525,268	
						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	Y	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
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

MCRIF32 - 16.7.171.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/31/2021 9:21 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/31/2021 9:21 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/05/2021	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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/31/2021 9:21 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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/31/2021 9:21 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.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	46	16,836	0.00	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)		46	16,836	0.00	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)		46	16,836	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		46				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/31/2021 9:21 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)	1,331	186	3,013			1.00
2.00	HMO and other (see instructions)	326	637				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	191	0	288			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,522	186	3,301			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		77	1,141			13.00
14.00	Total (see instructions)	1,522	263	4,442	0.00	205.94	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			47			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	12,193	4,764	49,373	0.00	11.06	26.00
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	217.00	27.00
28.00	Observation Bed Days		40	487			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			132			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	61	173			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	412	21	1,221	1.00
2.00 HMO and other (see instructions)			86	151		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	412	21	1,221	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	13,689,955	0	13,689,955	450,339.89	30.40 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		102,075	0	102,075	2,003.39	50.95 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		214,529	4,225	218,754	9,016.42	24.26 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		31,809	0	31,809	671.99	47.34 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		260,495	0	260,495	2,029.23	128.37 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		2,716,810	0	2,716,810	78,498.21	34.61 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,065,740	0	6,065,740		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		112,706	0	112,706		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		36,370	0	36,370		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		977,379	0	977,379		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	182,631	0	182,631	4,749.07	38.46	26.00
27.00	Administrative & General	5.00	1,657,254	-58,009	1,599,245	45,532.35	35.12	27.00
28.00	Administrative & General under contract (see inst.)		323,056	0	323,056	4,804.93	67.23	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	409,835	126	409,961	14,736.79	27.82	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	431,979	0	431,979	31,204.61	13.84	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	269,251	-206,650	62,601	6,860.48	9.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	206,650	206,650	13,375.00	15.45	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	834,801	-44,921	789,880	18,214.16	43.37	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	417,577	9,620	427,197	10,162.68	42.04	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	65,829	-3,291	62,538	2,082.97	30.02	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
1/31/2021 9:21 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	13,910,936	0	13,910,936	453,141.43	30.70	1.00
2.00	Excluded area salaries (see instructions)	214,529	4,225	218,754	9,016.42	24.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	13,696,407	-4,225	13,692,182	444,125.01	30.83	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,009,114	0	3,009,114	81,199.43	37.06	4.00
5.00	Subtotal wage-related costs (see inst.)	7,043,119	0	7,043,119	0.00	51.44	5.00
6.00	Total (sum of lines 3 thru 5)	23,748,640	-4,225	23,744,415	525,324.44	45.20	6.00
7.00	Total overhead cost (see instructions)	4,592,213	-96,475	4,495,738	151,723.04	29.63	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 1/31/2021 9:21 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		92,788	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		1,807,724	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		3,028,702	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		22,531	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		241,174	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		773,419	17.00
18.00	Medicare Taxes - Employers Portion Only		198,504	18.00
19.00	Unemployment Insurance		5,325	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		44,648	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,214,815	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	31,809	6,214,815	1.00
2.00	Hospital	31,809	6,214,815	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0145 Component CCN: 14-8503		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 1/31/2021 9:21 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			VARIOUS					1.00
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			VARIOUS			IL 62230		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:30			17:00		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y			6		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number			ST. JOSEPH'S HOSPITAL			148503		14.00
14.01				ST. JOSEPH'S HOSPITAL			148502		14.01
14.02				CLINTON COUNTY RURAL HEALTH			148552		14.02
14.03				TRENTON					
14.04				CLINTON CNTY RURAL HEALTH			148553		14.03
14.05				NEW BADEN					
14.06				CLINTON CTY RURAL HEALTH			148554		14.04
14.07				CARLYLE-BU					
14.08				CLINTON CNTY RURAL HLTH-			148570		14.05
14.09				CARLYLE RIV					
				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

MCRIF32 - 16.7.171.0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 1/31/2021 9:21 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)			0.346021 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,253,459		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	13,602,294		6.00
7.00	Medicaid cost (line 1 times line 6)	4,706,679		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,453,220		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,453,220		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,427,775	677,954	2,105,729 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	494,040	677,954	1,171,994 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	494,040	677,954	1,171,994 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)	1,593,081		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	151,542		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	233,141		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,359,940		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	552,167		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,724,161		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,177,381		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/31/2021 9:21 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,529,154	1,529,154	238,216	1,767,370	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	807,550	807,550	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	182,631	5,272,192	5,454,823	1,427,910	6,882,733	4.00
5.01	00540	NONPATIENT TELEPHONES	0	53,776	53,776	77,176	130,952	5.01
5.02	00550	DATA PROCESSING	-1,235	2,080,300	2,079,065	-111,175	1,967,890	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	106,340	141,891	248,231	427	248,658	5.03
5.04	00570	ADMITTING	0	1,823	1,823	-1,740	83	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMIN & GENERAL	1,552,149	10,663,191	12,215,340	-1,501,727	10,713,613	5.06
7.00	00700	OPERATION OF PLANT	409,835	1,320,078	1,729,913	94,389	1,824,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,043	142,043	-541	141,502	8.00
9.00	00900	HOUSEKEEPING	431,979	335,431	767,410	-1,036	766,374	9.00
10.00	01000	DIETARY	269,251	378,016	647,267	-497,937	149,330	10.00
11.00	01100	CAFETERIA	0	0	0	492,030	492,030	11.00
13.00	01300	NURSING ADMINISTRATION	834,801	62,865	897,666	-48,711	848,955	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	417,577	1,619,277	2,036,854	-1,429,687	607,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,544	9,544	-3,100	6,444	16.00
17.00	01700	SOCIAL SERVICE	65,829	5,182	71,011	-3,936	67,075	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	20,316	20,316	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,716,399	390,739	3,107,138	-1,083,485	2,023,653	30.00
31.00	03100	INTENSIVE CARE UNIT	0	893	893	-893	0	31.00
43.00	04300	NURSERY	51	175,472	175,523	206,463	381,986	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,182,652	1,941,017	3,123,669	-1,196,612	1,927,057	50.00
51.00	05100	RECOVERY ROOM	20,108	0	20,108	2,717	22,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,895	27,125	45,020	619,107	664,127	52.00
53.00	05300	ANESTHESIOLOGY	0	87,876	87,876	-47,437	40,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	901,260	445,759	1,347,019	-179,867	1,167,152	54.00
57.00	05700	CT SCAN	288	187,823	188,111	-41,671	146,440	57.00
58.00	05800	MRI	66,944	86,678	153,622	-1,209	152,413	58.00
60.00	06000	LABORATORY	938,563	1,350,220	2,288,783	-444,885	1,843,898	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	87,168	87,168	0	87,168	63.00
65.00	06500	RESPIRATORY THERAPY	377,881	169,983	547,864	-106,612	441,252	65.00
66.00	06600	PHYSICAL THERAPY	1,264,699	295,319	1,560,018	-63,199	1,496,819	66.00
69.00	06900	ELECTROCARDIOLOGY	9,611	102,628	112,239	-38,028	74,211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,347	6,772	8,119	-8,119	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	78,848	47,382	126,230	1,468,809	1,595,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	562,763	562,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,450,023	1,450,023	73.00
76.97	07697	CARDIAC REHABILITATION	78,339	4,421	82,760	3,713	86,473	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	572,698	8,663,911	9,236,609	-117,326	9,119,283	88.00
91.00	09100	EMERGENCY	978,686	1,191,838	2,170,524	-112,067	2,058,457	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	44,473	44,473	-8,872	35,601	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		340,965	340,965	-956	340,009	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,475,426	39,263,225	52,738,651	420,781	53,159,432	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	214,529	3,438,021	3,652,550	-412,531	3,240,019	192.00
194.00	07950	LIFELINE	0	0	0	3,291	3,291	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	11,541	11,541	-11,541	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,689,955	42,712,787	56,402,742	0	56,402,742	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	24,070	1,791,440	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	174,836	982,386	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,718,168	5,164,565	4.00
5.01	00540	NONPATIENT TELEPHONES	0	130,952	5.01
5.02	00550	DATA PROCESSING	1,146,112	3,114,002	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-40	248,618	5.03
5.04	00570	ADMITTING	386,801	386,884	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	894,895	894,895	5.05
5.06	00590	ADMIN & GENERAL	-6,906,086	3,807,527	5.06
7.00	00700	OPERATION OF PLANT	-3,482	1,820,820	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-11,162	130,340	8.00
9.00	00900	HOUSEKEEPING	0	766,374	9.00
10.00	01000	DIETARY	0	149,330	10.00
11.00	01100	CAFETERIA	-42,720	449,310	11.00
13.00	01300	NURSING ADMINISTRATION	-21,383	827,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	607,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	817,223	823,667	16.00
17.00	01700	SOCIAL SERVICE	0	67,075	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-20,316	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,023,653	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	-159,429	222,557	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-464,230	1,462,827	50.00
51.00	05100	RECOVERY ROOM	0	22,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	664,127	52.00
53.00	05300	ANESTHESIOLOGY	0	40,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,167,152	54.00
57.00	05700	CT SCAN	0	146,440	57.00
58.00	05800	MRI	0	152,413	58.00
60.00	06000	LABORATORY	-23,212	1,820,686	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	87,168	63.00
65.00	06500	RESPIRATORY THERAPY	-12,312	428,940	65.00
66.00	06600	PHYSICAL THERAPY	-30,602	1,466,217	66.00
69.00	06900	ELECTROCARDIOLOGY	-36,203	38,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,595,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	562,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,450,023	73.00
76.97	07697	CARDIAC REHABILITATION	0	86,473	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	643,462	9,762,745	88.00
91.00	09100	EMERGENCY	-1,056,090	1,002,367	91.00
91.01	09101	PRIORITY CARE CARLYLE	-28	35,573	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-340,009	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,758,073	46,401,359	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	-71,752	3,168,267	192.00
194.00	07950	LIFELINE	0	3,291	194.00
194.01	07951	DEVELOPMENT	0	0	194.01
194.02	07952	VACANT SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,829,825	49,572,917	200.00

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
1/31/2021 9:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS NON-PHYSICIAN ANESTHETISTIS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	20,316		1.00
	0		0	20,316		
	B - TO RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	206,650	285,380		1.00
	0		206,650	285,380		
	C - TO RECLASS MANAGERS SALARY					
1.00	ADMIN & GENERAL	5.06	16,377	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	28,110	0		2.00
3.00	NURSERY	43.00	31	0		3.00
4.00	RECOVERY ROOM	51.00	2,287	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	1,127	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	837	0		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	13,209	0		7.00
8.00	PHARMACY	15.00	9,230	0		8.00
9.00	CARDIAC REHABILITATION	76.97	6,269	0		9.00
	0		77,477	0		
	D - RECLASS SOCIAL SERV SLRY TO LIFELIN					
1.00	LIFELINE	194.00	3,291	0		1.00
	0		3,291	0		
	E - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,450,023		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	156		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	1,450,179		
	F - PLANT OP RECLASS					
1.00	OPERATION OF PLANT	7.00	0	133,096		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	171		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	133,267		
	G - TELEPHONE RECLASS					
1.00	NONPATIENT TELEPHONES	5.01	0	77,454		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	77,454		
	I - IMPLANTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,456,216		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	562,763		2.00
3.00	PHARMACY	15.00	0	6,955		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	0		0	2,025,934		

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
1/31/2021 9:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	238,216	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	807,550	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
	0		0	1,045,766		
	L - SALARY CORRECTION RECLASS					
1.00	NURSERY	43.00	212,805	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	643,351	0	2.00	
3.00	ELECTROCARDIOLOGY	69.00	1,347	6,772	3.00	
4.00	DATA PROCESSING	5.02	1,235	0	4.00	
	0		858,738	6,772		
	N - COVID EXPENSES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,429,402	1.00	
2.00	PURCHASING RECEIVING AND STORES	5.03	1,240	0	2.00	
3.00	ADMITTING	5.04	83	0	3.00	
4.00	OPERATION OF PLANT	7.00	126	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	929	0	5.00	
6.00	PHARMACY	15.00	390	0	6.00	
7.00	ADULTS & PEDIATRICS	30.00	3,860	0	7.00	
8.00	OPERATING ROOM	50.00	42,087	0	8.00	
9.00	RECOVERY ROOM	51.00	430	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,395	0	10.00	
11.00	LABORATORY	60.00	299	0	11.00	
12.00	RESPIRATORY THERAPY	65.00	798	0	12.00	
13.00	PHYSICAL THERAPY	66.00	19,845	0	13.00	
14.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	1,293	2,463	14.00	
15.00	PHYSICIANS PRIVATE OFFICES	192.00	934	0	15.00	
	TOTALS		75,709	1,431,865		
	O - ICU					
1.00	ADULTS & PEDIATRICS	30.00	0	893	1.00	
	TOTALS		0	893		
500.00	Grand Total: Increases		1,221,865	6,477,826	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/31/2021 9:21 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS NON-PHYSICIAN ANESTHETISTS						
1.00	ANESTHESIOLOGY	53.00	0	20,316	0		1.00
	0		0	20,316			
	B - TO RECLASS CAFETERIA COST						
1.00	DIETARY	10.00	206,650	285,380	0		1.00
	0		206,650	285,380			
	C - TO RECLASS MANAGERS SALARY						
1.00	NURSING ADMINISTRATION	13.00	45,850	0	0		1.00
2.00	OPERATING ROOM	50.00	24,521	0	0		2.00
3.00	RESPIRATORY THERAPY	65.00	7,106	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
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		77,477	0			
	D - RECLASS SOCIAL SERV SLRY TO LIFELIN						
1.00	SOCIAL SERVICE	17.00	3,291	0	0		1.00
	0		3,291	0			
	E - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	1,435,030	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,088	0		2.00
3.00	OPERATING ROOM	50.00	0	9,629	0		3.00
4.00	LABORATORY	60.00	0	63	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	5	0		5.00
6.00	EMERGENCY	91.00	0	1,364	0		6.00
	0		0	1,450,179			
	F - PLANT OP RECLASS						
1.00	PHARMACY	15.00	0	7,073	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,525	0		2.00
3.00	OPERATING ROOM	50.00	0	484	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	378	0		4.00
5.00	LABORATORY	60.00	0	763	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	84	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	33,166	0		7.00
8.00	EMERGENCY	91.00	0	410	0		8.00
9.00	PHYSICIANS PRIVATE OFFICES	192.00	0	77,843	0		9.00
10.00	VACANT SPACE	194.02	0	11,541	0		10.00
	0		0	133,267			
	G - TELEPHONE RECLASS						
1.00	DATA PROCESSING	5.02	0	5,613	0		1.00
2.00	ADMIN & GENERAL	5.06	0	2,173	0		2.00
3.00	OPERATION OF PLANT	7.00	0	964	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	50,156	0		4.00
5.00	PRIORITY CARE CARLYLE	91.01	0	1,500	0		5.00
6.00	PHYSICIANS PRIVATE OFFICES	192.00	0	17,048	0		6.00
	0		0	77,454			
	I - IMPLANTS RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	180,360	0		1.00
2.00	NURSERY	43.00	0	934	0		2.00
3.00	OPERATING ROOM	50.00	0	1,107,832	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,652	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	9,970	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,598	0		6.00
7.00	CT SCAN	57.00	0	8,883	0		7.00
8.00	MRI	58.00	0	769	0		8.00
9.00	LABORATORY	60.00	0	401,541	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	88,756	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	71,498	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	24,578	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	79	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	1,466	0		14.00
15.00	EMERGENCY	91.00	0	88,982	0		15.00
16.00	PRIORITY CARE CARLYLE	91.01	0	36	0		16.00
	0		0	2,025,934			
	J - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,492	9		1.00
2.00	NONPATIENT TELEPHONES	5.01	0	278	9		2.00
3.00	DATA PROCESSING	5.02	0	106,797	0		3.00
4.00	PURCHASING RECEIVING AND STORES	5.03	0	813	0		4.00
5.00	ADMITTING	5.04	0	1,823	0		5.00
6.00	ADMIN & GENERAL	5.06	0	7,122	0		6.00

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/31/2021 9:21 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	OPERATION OF PLANT	7.00	0	37,869	0		7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	541	0		8.00
9.00	HOUSEKEEPING	9.00	0	1,036	0		9.00
10.00	DIETARY	10.00	0	5,907	0		10.00
11.00	NURSING ADMINISTRATION	13.00	0	3,790	0		11.00
12.00	PHARMACY	15.00	0	4,159	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,100	0		13.00
14.00	SOCIAL SERVICE	17.00	0	645	0		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	74,219	0		15.00
17.00	NURSERY	43.00	0	5,439	0		17.00
18.00	OPERATING ROOM	50.00	0	96,233	0		18.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	0	18,719	0		20.00
21.00	ANESTHESIOLOGY	53.00	0	17,151	0		21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	0	149,286	0		22.00
23.00	CT SCAN	57.00	0	32,788	0		23.00
24.00	MRI	58.00	0	440	0		24.00
25.00	LABORATORY	60.00	0	42,817	0		25.00
26.00	RESPIRATORY THERAPY	65.00	0	11,548	0		26.00
27.00	PHYSICAL THERAPY	66.00	0	11,457	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	0	15,814	0		28.00
29.00	ELECTROCARDIOLOGY	69.00	0	6,513	0		29.00
30.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	4,699	0		30.00
31.00	CARDIAC REHABILITATION	76.97	0	1,090	0		31.00
32.00	RURAL HEALTH CLINIC	88.00	0	34,004	0		32.00
33.00	EMERGENCY	91.00	0	21,311	0		33.00
34.00	PRIORITY CARE CARLYLE	91.01	0	7,336	0		34.00
35.00	INTEREST EXPENSE	113.00	0	956	0		35.00
36.00	PHYSICIANS PRIVATE OFFICES	192.00	0	318,574	0		36.00
	0		0	1,045,766			
L - SALARY CORRECTION RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	856,156	0	0		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	1,347	6,772	0		2.00
3.00	ADMIN & GENERAL	5.06	1,235	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		858,738	6,772			
N - COVID EXPENSES							
1.00	ADMIN & GENERAL	5.06	75,709	1,431,865	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	TOTALS		75,709	1,431,865			
O - ICU							
1.00	INTENSIVE CARE UNIT	31.00	0	893	0		1.00
	TOTALS		0	893			
500.00	Grand Total: Decreases		1,221,865	6,477,826			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,704,211	0	0	0	0	1.00
2.00	Land Improvements	4,719,471	36,403	0	36,403	0	2.00
3.00	Buildings and Fixtures	43,754,406	1,357,927	0	1,357,927	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,119,173	804,266	0	804,266	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,297,261	2,198,596	0	2,198,596	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,297,261	2,198,596	0	2,198,596	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,704,211	0				1.00
2.00	Land Improvements	4,755,874	0				2.00
3.00	Buildings and Fixtures	45,112,333	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	26,923,439	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	78,495,857	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	78,495,857	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,529,154	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,529,154	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,529,154				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,529,154				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	51,572,417	0	51,572,417	0.659844	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,923,439	337,320	26,586,119	0.340156	0	2.00
3.00	Total (sum of lines 1-2)	78,495,856	337,320	78,158,536	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,791,440	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	982,386	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,773,826	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,791,440	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	982,386	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,773,826	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,369	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,798,671			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	-684,854			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-42,720	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B		0	0.00	0	16.00
17.00	Sale of drugs to other than patients	B		0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B		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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-20,316	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST EXPENSE	B	-340,009	INTEREST EXPENSE	113.00	11	33.00
33.01	DEFINED PENSION ADJUSTMENT	A	304,470	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-40	PURCHASING RECEIVING AND STORES	5.03	0	33.02
33.03	MISCELLANEOUS INCOME	B	-89,336	ADMIN & GENERAL	5.06	0	33.03
33.04	MISCELLANEOUS INCOME	B	-6,744	PHYSICAL THERAPY	66.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-1	LABORATORY	60.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-3,985	RURAL HEALTH CLINIC	88.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-113	OPERATION OF PLANT	7.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-540	NURSING ADMINISTRATION	13.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-320	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
35.00	BANK FEES	B	823	RURAL HEALTH CLINIC	88.00	0	35.00
35.01	BANK FEES	B	-1,593	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.01
36.00	LOBBYING EXPENSES	A	-16,993	ADMIN & GENERAL	5.06	0	36.00
37.00	MARKETING & COMMUNITY BENEFIT SALARY	A	-114,852	ADMIN & GENERAL	5.06	0	37.00
38.00	MARKETING & COMMUNITY BENEFIT BENEFI	A	-31,632	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MARKETING & COMMUNITY BENEFIT OTHER	A	-186,896	ADMIN & GENERAL	5.06	0	39.00
39.01	CRNA BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.01
39.02	MEDICAID PROVIDER TAX	A	-1,796,854	ADMIN & GENERAL	5.06	0	39.02
39.03	ALCOHOL EXPENSE	A	-1,330	ADMIN & GENERAL	5.06	0	39.03
39.04	NONALLOWABLE EXPENSE	A	-2,341	ADMIN & GENERAL	5.06	0	39.04
40.00	EMPLOYEE SELF-INSURANCE	A	-1,988,905	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	MEDICAL GROUP EXPENSE	A	0	PHYSICIANS PRIVATE OFFICES	192.00	0	41.00
43.00	PROPERTY TAX OFFSET	A	-71,752	PHYSICIANS PRIVATE OFFICES	192.00	0	43.00
43.01	PROPERTY TAX OFFSET	A	-32,933	ADMIN & GENERAL	5.06	0	43.01
43.02	PROPERTY TAX OFFSET	A	0	OPERATION OF PLANT	7.00	0	43.02
43.03	BUILDING RELIFING	A	24,070	CAP REL COSTS-BLDG & FIXT	1.00	9	43.03
43.04	EQUIPMENT RELIFING	A	174,836	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.04
44.00	RESTRUCTURING EXPENSE	A	-96,925	ADMIN & GENERAL	5.06	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,829,825				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
1/31/2021 9:21 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS - HEALTH &	3,840,852	3,841,040	1.00
2.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS -- ISC M	3,078,634	1,932,522	2.00
3.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	CASHIER/AR SBO	894,895	0	3.00
4.00	5.04	ADMITTING	ADMITTING SBO	386,801	0	4.00
4.01	5.06	ADMIN & GENERAL	ADMIN-SBO	126,634	4,395,640	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	MED REC-SBO	817,223	0	4.02
4.03	5.06	ADMIN & GENERAL	SSC CONTRACTED SVCS	1,119,397	1,301,485	4.03
4.04	5.06	ADMIN & GENERAL	ADMIN PURCHASED SVCS	0	57,283	4.04
4.05	5.06	ADMIN & GENERAL	SID-A&G	536,292	591,594	4.05
4.06	13.00	NURSING ADMINISTRATION	SID - FLOAT POOL	88,891	88,891	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	SID - HR	280,317	280,317	4.07
4.08	60.00	LABORATORY	SID - LAB	5,318	5,318	4.08
4.09	15.00	PHARMACY	SID - SHARED PHARMACIST	48,522	48,522	4.09
4.10	8.00	LAUNDRY & LINEN SERVICE	CID - LAUNDRY	130,253	141,415	4.10
4.11	5.06	ADMIN & GENERAL	CID - LIBRARY	17,266	18,746	4.11
4.12	88.00	RURAL HEALTH CLINIC	RHC - MED GROUP MANAGEMENT F	646,624	0	4.12
4.13	5.06	ADMIN & GENERAL	RELATED PARTY TRANSACTIONS	12,259,702	12,259,702	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,277,621	24,962,475	5.00

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

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

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

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

6.00	B		100.00	HSHS	0.00	6.00
7.00	G		0.00	HSHS MEDICAL GROUP	0.00	7.00
8.00	G		0.00	ST. ELIZABETH BELLEVILLE	0.00	8.00
9.00	G		0.00	ST. JOHNS HOSPITAL	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	SISTER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
1/31/2021 9:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-188	0		1.00
2.00	1,146,112	0		2.00
3.00	894,895	0		3.00
4.00	386,801	0		4.00
4.01	-4,269,006	0		4.01
4.02	817,223	0		4.02
4.03	-182,088	0		4.03
4.04	-57,283	0		4.04
4.05	-55,302	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	-11,162	0		4.10
4.11	-1,480	0		4.11
4.12	646,624	0		4.12
4.13	0	0		4.13
5.00	-684,854			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	CORPORATE OFFICE		6.00
7.00	PHYSICIAN OFFICES		7.00
8.00	SISTER HOSPITAL		8.00
9.00	SISTER HOSPITAL		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
1/31/2021 9:21 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	5.06	ADMIN & GENERAL	7,856	0	7,856	211,500	53	1.00
2.00	43.00	NURSERY	162,886	158,686	4,200	211,500	34	2.00
3.00	50.00	OPERATING ROOM	464,230	464,230	0	246,400	0	3.00
4.00	60.00	LABORATORY	109,060	21,895	87,165	260,300	686	4.00
5.00	65.00	RESPIRATORY THERAPY	66,000	0	66,000	211,500	528	5.00
6.00	66.00	PHYSICAL THERAPY	97,476	2,738	94,738	211,500	724	6.00
7.00	69.00	ELECTROCARDIOLOGY	36,203	36,203	0	211,500	0	7.00
8.00	91.00	EMERGENCY	1,056,090	1,056,090	0	211,500	0	8.00
9.00	91.01	PRIORITY CARE CARLYLE	536	0	536	211,500	5	9.00
10.00	13.00	NURSING ADMINISTRATION	20,843	20,843	0	211,500	0	10.00
200.00			2,021,180	1,760,685	260,495		2,030	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	ADMIN & GENERAL	5,389	269	0	0	0	1.00
2.00	43.00	NURSERY	3,457	173	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	85,849	4,292	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	53,688	2,684	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	73,618	3,681	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.01	PRIORITY CARE CARLYLE	508	25	0	0	0	9.00
10.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	10.00
200.00			222,509	11,124	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	ADMIN & GENERAL	0	5,389	2,467	2,467		1.00
2.00	43.00	NURSERY	0	3,457	743	159,429		2.00
3.00	50.00	OPERATING ROOM	0	0	0	464,230		3.00
4.00	60.00	LABORATORY	0	85,849	1,316	23,211		4.00
5.00	65.00	RESPIRATORY THERAPY	0	53,688	12,312	12,312		5.00
6.00	66.00	PHYSICAL THERAPY	0	73,618	21,120	23,858		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	36,203		7.00
8.00	91.00	EMERGENCY	0	0	0	1,056,090		8.00
9.00	91.01	PRIORITY CARE CARLYLE	0	508	28	28		9.00
10.00	13.00	NURSING ADMINISTRATION	0	0	0	20,843		10.00
200.00			0	222,509	37,986	1,798,671		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,791,440	1,791,440			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	982,386		982,386		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,164,565	3,709	1,992	5,170,266	4.00
5.01	00540	NONPATIENT TELEPHONES	130,952	2,357	371		5.01
5.02	00550	DATA PROCESSING	3,114,002	19,249	142,622		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	248,618	26,909	1,086	41,179	5.03
5.04	00570	ADMITTING	386,884	29,712	2,435	32	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	894,895	11,332	0	0	5.05
5.06	00590	ADMIN & GENERAL	3,807,527	459,734	9,147	570,940	5.06
7.00	00700	OPERATION OF PLANT	1,820,820	126,585	50,572	156,923	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,340	30,347	722	0	8.00
9.00	00900	HOUSEKEEPING	766,374	14,973	1,384	165,351	9.00
10.00	01000	DIETARY	149,330	25,512	7,889	23,962	10.00
11.00	01100	CAFETERIA	449,310	16,227	0	79,100	11.00
13.00	01300	NURSING ADMINISTRATION	827,572	5,092	5,061	302,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	607,167	8,083	5,554	163,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	823,667	9,942	4,140	0	16.00
17.00	01700	SOCIAL SERVICE	67,075	1,685	861	23,938	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,023,653	119,332	99,116	724,293	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	222,557	7,298	7,264	81,488	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,462,827	142,041	128,515	459,413	50.00
51.00	05100	RECOVERY ROOM	22,825	5,560	0	8,737	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	664,127	24,341	24,998	253,540	52.00
53.00	05300	ANESTHESIOLOGY	40,439	1,466	22,904	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,167,152	35,340	199,364	346,279	54.00
57.00	05700	CT SCAN	146,440	3,468	43,787	110	57.00
58.00	05800	MRI	152,413	5,485	588	25,624	58.00
60.00	06000	LABORATORY	1,820,686	16,665	57,180	359,373	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	87,168	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	428,940	8,197	15,422	142,229	65.00
66.00	06600	PHYSICAL THERAPY	1,466,217	94,039	15,300	491,691	66.00
69.00	06900	ELECTROCARDIOLOGY	38,008	0	29,817	4,515	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,595,039	6,406	6,275	35,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	562,763	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,450,023	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	86,473	15,230	1,456	32,386	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	9,762,745	208,204	23,026	219,214	88.00
91.00	09100	EMERGENCY	1,002,367	41,369	28,460	374,617	91.00
91.01	09101	PRIORITY CARE CARLYLE	35,573	13,470	12,022	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,401,359	1,539,359	949,330	5,086,532	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,168,267	252,081	33,056	82,474	192.00
194.00	07950	LIFELINE	3,291	0	0	1,260	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	49,572,917	1,791,440	982,386	5,170,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,282,827					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	318,758				5.03
5.04	00570	ADMITTING	0	0	420,029			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,282,827	0	0	4,189,054		5.05
5.06	00590	ADMIN & GENERAL	0	1,910	0	0	4,864,326	5.06
7.00	00700	OPERATION OF PLANT	0	5,007	0	0	2,164,350	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6	0	0	161,608	8.00
9.00	00900	HOUSEKEEPING	0	1,552	0	0	950,986	9.00
10.00	01000	DIETARY	0	319	0	0	208,557	10.00
11.00	01100	CAFETERIA	0	0	0	0	544,637	11.00
13.00	01300	NURSING ADMINISTRATION	0	112	0	0	1,141,149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	166	0	0	785,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	843,544	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	94,718	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,548	12,357	123,231	3,130,065	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	410	3,602	35,921	358,540	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,015	36,842	367,426	2,614,545	50.00
51.00	05100	RECOVERY ROOM	0	0	7,303	72,830	117,255	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42	10,889	108,596	1,086,533	52.00
53.00	05300	ANESTHESIOLOGY	0	59	13,035	129,992	208,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,078	43,467	433,490	2,234,420	54.00
57.00	05700	CT SCAN	0	2,568	52,849	527,054	776,276	57.00
58.00	05800	MRI	0	271	14,048	140,101	338,530	58.00
60.00	06000	LABORATORY	0	10,815	86,778	865,574	3,220,741	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	5,456	1,724	17,198	111,546	63.00
65.00	06500	RESPIRATORY THERAPY	0	11	4,244	42,324	643,492	65.00
66.00	06600	PHYSICAL THERAPY	0	263	18,025	179,764	2,272,447	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,716	5,488	54,734	134,278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	98,837	8,413	83,907	1,834,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,095	3,655	36,447	639,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,580	35,490	353,939	1,935,032	73.00
76.97	07697	CARDIAC REHABILITATION	0	123	706	7,039	144,186	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	32,531	33,976	338,839	10,635,148	88.00
91.00	09100	EMERGENCY	0	387	27,010	269,367	1,747,054	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	25	128	1,281	62,499	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,282,827	311,902	420,029	4,189,054	46,004,575	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,856	0	0	3,563,791	192.00
194.00	07950	LIFELINE	0	0	0	0	4,551	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	3,282,827	318,758	420,029	4,189,054	49,572,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL	4,864,326					5.06
7.00	00700	OPERATION OF PLANT	235,483	2,399,833				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,583	65,501	244,692			8.00
9.00	00900	HOUSEKEEPING	103,468	32,318	0	1,086,772		9.00
10.00	01000	DIETARY	22,691	55,065	0	0	286,313	10.00
11.00	01100	CAFETERIA	59,257	35,025	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	124,158	10,990	0	6,567	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	85,458	17,447	0	9,850	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91,778	21,459	0	6,567	0	16.00
17.00	01700	SOCIAL SERVICE	10,305	3,636	0	3,283	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	340,554	257,568	107,668	229,832	278,001	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	39,010	15,751	0	13,133	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	284,465	306,583	43,194	124,765	0	50.00
51.00	05100	RECOVERY ROOM	12,757	12,001	0	19,700	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,216	52,538	0	13,133	0	52.00
53.00	05300	ANESTHESIOLOGY	22,640	3,163	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243,107	76,279	32,192	59,099	1,250	54.00
57.00	05700	CT SCAN	84,460	7,484	0	6,567	0	57.00
58.00	05800	MRI	36,832	11,838	0	6,567	0	58.00
60.00	06000	LABORATORY	350,420	35,971	0	26,266	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	12,136	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	70,013	17,692	135	9,850	0	65.00
66.00	06600	PHYSICAL THERAPY	247,245	202,975	1,924	26,266	0	66.00
69.00	06900	ELECTROCARDIOLOGY	14,610	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	199,607	13,827	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,628	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,533	0	0	19,700	0	73.00
76.97	07697	CARDIAC REHABILITATION	15,688	32,873	0	13,133	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,157,104	449,390	184	187,148	0	88.00
91.00	09100	EMERGENCY	190,081	89,291	40,901	91,932	7,062	91.00
91.01	09101	PRIORITY CARE CARLYLE	6,800	29,073	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,476,087	1,855,738	226,198	873,358	286,313	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	387,744	544,095	18,494	213,414	0	192.00
194.00	07950	LIFELINE	495	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	4,864,326	2,399,833	244,692	1,086,772	286,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	638,919					11.00
13.00	01300	NURSING ADMINISTRATION	31,614	1,314,478				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	17,648	70,845	0	986,704		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	963,348	16.00
17.00	01700	SOCIAL SERVICE	3,609	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	101,194	406,520	0	197	241,631	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	10,899	43,819	0	0	187,583	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,073	249,432	0	0	120,816	50.00
51.00	05100	RECOVERY ROOM	1,155	4,580	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,573	138,839	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,122	0	0	0	96,971	54.00
57.00	05700	CT SCAN	614	0	0	0	0	57.00
58.00	05800	MRI	3,717	0	0	0	0	58.00
60.00	06000	LABORATORY	61,820	0	0	0	151,020	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	23,241	0	0	0	12,717	65.00
66.00	06600	PHYSICAL THERAPY	73,946	0	0	0	15,897	66.00
69.00	06900	ELECTROCARDIOLOGY	722	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,568	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	733,384	0	73.00
76.97	07697	CARDIAC REHABILITATION	5,413	21,805	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	99,497	160,351	0	253,122	0	88.00
91.00	09100	EMERGENCY	38,868	156,197	0	1	136,713	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	623,293	1,252,388	0	986,704	963,348	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	15,446	62,090	0	0	0	192.00
194.00	07950	LIFELINE	180	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	638,919	1,314,478	0	986,704	963,348	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	115,551					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	107,483	0	5,200,713	0	5,200,713	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	668,735	0	668,735	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,465	0	3,811,338	0	3,811,338	50.00
51.00	05100	RECOVERY ROOM	0	0	167,448	0	167,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,443,832	0	1,443,832	52.00
53.00	05300	ANESTHESIOLOGY	0	0	233,891	0	233,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,789,440	0	2,789,440	54.00
57.00	05700	CT SCAN	0	0	875,401	0	875,401	57.00
58.00	05800	MRI	0	0	397,484	0	397,484	58.00
60.00	06000	LABORATORY	0	0	3,846,238	0	3,846,238	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	123,682	0	123,682	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	777,140	0	777,140	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,840,700	0	2,840,700	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	149,610	0	149,610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	2,054,611	0	2,054,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	709,588	0	709,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,898,649	0	2,898,649	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	233,098	0	233,098	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	12,941,944	0	12,941,944	88.00
91.00	09100	EMERGENCY	2,603	0	2,500,703	0	2,500,703	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	98,372	0	98,372	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,551	0	44,762,617	0	44,762,617	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	4,805,074	0	4,805,074	192.00
194.00	07950	LIFELINE	0	0	5,226	0	5,226	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	115,551	0	49,572,917	0	49,572,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,709	1,992	5,701	4.00
5.01	00540	NONPATIENT TELEPHONES	0	2,357	371	2,728	5.01
5.02	00550	DATA PROCESSING	760,291	19,249	142,622	922,162	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	26,909	1,086	27,995	5.03
5.04	00570	ADMITTING	0	29,712	2,435	32,147	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	24,941	11,332	0	36,273	5.05
5.06	00590	ADMIN & GENERAL	53,809	459,734	9,147	522,690	5.06
7.00	00700	OPERATION OF PLANT	0	126,585	50,572	177,157	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,347	722	31,069	8.00
9.00	00900	HOUSEKEEPING	0	14,973	1,384	16,357	9.00
10.00	01000	DIETARY	0	25,512	7,889	33,401	10.00
11.00	01100	CAFETERIA	0	16,227	0	16,227	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,092	5,061	10,153	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	8,083	5,554	13,637	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,942	4,140	14,082	16.00
17.00	01700	SOCIAL SERVICE	0	1,685	861	2,546	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	119,332	99,116	218,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	7,298	7,264	14,562	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	88,395	142,041	128,515	358,951	50.00
51.00	05100	RECOVERY ROOM	0	5,560	0	5,560	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,341	24,998	49,339	52.00
53.00	05300	ANESTHESIOLOGY	0	1,466	22,904	24,370	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,340	199,364	234,704	54.00
57.00	05700	CT SCAN	0	3,468	43,787	47,255	57.00
58.00	05800	MRI	0	5,485	588	6,073	58.00
60.00	06000	LABORATORY	2,881	16,665	57,180	76,726	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,197	15,422	23,619	65.00
66.00	06600	PHYSICAL THERAPY	0	94,039	15,300	109,339	66.00
69.00	06900	ELECTROCARDIOLOGY	180	0	29,817	29,997	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,188	6,406	6,275	14,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	15,230	1,456	16,686	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	117,649	208,204	23,026	348,879	88.00
91.00	09100	EMERGENCY	0	41,369	28,460	69,829	91.00
91.01	09101	PRIORITY CARE CARLYLE	34,681	13,470	12,022	60,173	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,085,015	1,539,359	949,330	3,573,704	5,609
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	252,081	33,056	285,137	91
194.00	07950	LIFELINE	0	0	0	0	1
194.01	07951	DEVELOPMENT	0	0	0	0	0
194.02	07952	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,085,015	1,791,440	982,386	3,858,841	5,701

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	2,728					5.01
5.02	00550	DATA PROCESSING	142	922,304				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	20	0	28,060			5.03
5.04	00570	ADMITTING	20	0	0	32,167		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	922,304	0	0	958,577	5.05
5.06	00590	ADMIN & GENERAL	307	0	168	0	0	5.06
7.00	00700	OPERATION OF PLANT	91	0	441	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4	0	1	0	0	8.00
9.00	00900	HOUSEKEEPING	28	0	137	0	0	9.00
10.00	01000	DIETARY	32	0	28	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	20	0	10	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	20	0	15	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	24	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	498	0	312	948	28,199	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	36	276	8,220	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	193	0	706	2,825	84,078	50.00
51.00	05100	RECOVERY ROOM	0	0	0	560	16,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4	835	24,850	52.00
53.00	05300	ANESTHESIOLOGY	4	0	5	1,000	29,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87	0	447	3,333	99,196	54.00
57.00	05700	CT SCAN	0	0	226	4,053	120,606	57.00
58.00	05800	MRI	0	0	24	1,077	32,059	58.00
60.00	06000	LABORATORY	75	0	952	6,613	198,063	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	480	132	3,935	63.00
65.00	06500	RESPIRATORY THERAPY	43	0	1	325	9,685	65.00
66.00	06600	PHYSICAL THERAPY	146	0	23	1,382	41,136	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	151	421	12,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	8,698	645	19,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,266	280	8,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,414	2,722	80,992	73.00
76.97	07697	CARDIAC REHABILITATION	16	0	11	54	1,611	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	339	0	2,864	2,605	77,537	88.00
91.00	09100	EMERGENCY	71	0	34	2,071	61,640	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	2	10	293	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,298	922,304	27,456	32,167	958,577	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	430	0	604	0	0	192.00
194.00	07950	LIFELINE	0	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	2,728	922,304	28,060	32,167	958,577	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL	523,794					5.06
7.00	00700	OPERATION OF PLANT	25,358	203,220				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,893	5,547	38,514			8.00
9.00	00900	HOUSEKEEPING	11,142	2,737	0	30,583		9.00
10.00	01000	DIETARY	2,443	4,663	0	0	40,593	10.00
11.00	01100	CAFETERIA	6,381	2,966	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,370	931	0	185	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	9,202	1,477	0	277	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,883	1,817	0	185	0	16.00
17.00	01700	SOCIAL SERVICE	1,110	308	0	92	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,672	21,811	16,946	6,467	39,415	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	4,201	1,334	0	370	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,632	25,962	6,799	3,511	0	50.00
51.00	05100	RECOVERY ROOM	1,374	1,016	0	554	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,730	4,449	0	370	0	52.00
53.00	05300	ANESTHESIOLOGY	2,438	268	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,178	6,459	5,067	1,663	177	54.00
57.00	05700	CT SCAN	9,095	634	0	185	0	57.00
58.00	05800	MRI	3,966	1,002	0	185	0	58.00
60.00	06000	LABORATORY	37,734	3,046	0	739	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	1,307	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,539	1,498	21	277	0	65.00
66.00	06600	PHYSICAL THERAPY	26,624	17,188	303	739	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,573	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	21,494	1,171	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,498	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,671	0	0	554	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,689	2,784	0	370	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	124,591	38,055	29	5,267	0	88.00
91.00	09100	EMERGENCY	20,468	7,561	6,438	2,587	1,001	91.00
91.01	09101	PRIORITY CARE CARLYLE	732	2,462	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	481,988	157,146	35,603	24,577	40,593	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	41,753	46,074	2,911	6,006	0	192.00
194.00	07950	LIFELINE	53	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	523,794	203,220	38,514	30,583	40,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	25,661					11.00
13.00	01300	NURSING ADMINISTRATION	1,270	26,272				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	709	1,416	0	26,933		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	26,085	16.00
17.00	01700	SOCIAL SERVICE	145	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,065	8,124	0	5	6,544	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	438	876	0	0	5,079	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,493	4,985	0	0	3,271	50.00
51.00	05100	RECOVERY ROOM	46	92	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,389	2,775	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,852	0	0	0	2,626	54.00
57.00	05700	CT SCAN	25	0	0	0	0	57.00
58.00	05800	MRI	149	0	0	0	0	58.00
60.00	06000	LABORATORY	2,483	0	0	0	4,089	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	933	0	0	0	344	65.00
66.00	06600	PHYSICAL THERAPY	2,970	0	0	0	430	66.00
69.00	06900	ELECTROCARDIOLOGY	29	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	264	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	20,019	0	73.00
76.97	07697	CARDIAC REHABILITATION	217	436	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,996	3,205	0	6,909	0	88.00
91.00	09100	EMERGENCY	1,561	3,122	0	0	3,702	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,034	25,031	0	26,933	26,085	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	620	1,241	0	0	0	192.00
194.00	07950	LIFELINE	7	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	25,661	26,272	0	26,933	26,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,251					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,954		393,210	0	393,210	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		35,482	0	35,482	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	201		525,113	0	525,113	50.00
51.00	05100	RECOVERY ROOM	0		25,878	0	25,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		97,021	0	97,021	52.00
53.00	05300	ANESTHESIOLOGY	0		57,831	0	57,831	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		382,171	0	382,171	54.00
57.00	05700	CT SCAN	0		182,079	0	182,079	57.00
58.00	05800	MRI	0		44,563	0	44,563	58.00
60.00	06000	LABORATORY	0		330,916	0	330,916	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0		5,854	0	5,854	63.00
65.00	06500	RESPIRATORY THERAPY	0		44,442	0	44,442	65.00
66.00	06600	PHYSICAL THERAPY	0		200,822	0	200,822	66.00
69.00	06900	ELECTROCARDIOLOGY	0		44,701	0	44,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		66,380	0	66,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		19,384	0	19,384	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		135,372	0	135,372	73.00
76.97	07697	CARDIAC REHABILITATION	0		23,910	0	23,910	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		614,518	0	614,518	88.00
91.00	09100	EMERGENCY	96		180,594	0	180,594	91.00
91.01	09101	PRIORITY CARE CARLYLE	0		63,672	0	63,672	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,251	0	3,473,913	0	3,473,913	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		384,867	0	384,867	192.00
194.00	07950	LIFELINE	0		61	0	61	194.00
194.01	07951	DEVELOPMENT	0		0	0	0	194.01
194.02	07952	VACANT SPACE	0		0	0	0	194.02
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,251	0	3,858,841	0	3,858,841	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	237,133					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		735,620				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	491	1,492	13,507,324			4.00
5.01	00540	NONPATIENT TELEPHONES	312	278	0	692		5.01
5.02	00550	DATA PROCESSING	2,548	106,797	0	36	100	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	3,562	813	107,580	5	0	5.03
5.04	00570	ADMITTING	3,933	1,823	83	5	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,500	0	0	0	100	5.05
5.06	00590	ADMIN & GENERAL	60,855	6,849	1,491,582	78	0	5.06
7.00	00700	OPERATION OF PLANT	16,756	37,869	409,961	23	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	541	0	1	0	8.00
9.00	00900	HOUSEKEEPING	1,982	1,036	431,979	7	0	9.00
10.00	01000	DIETARY	3,377	5,907	62,601	8	0	10.00
11.00	01100	CAFETERIA	2,148	0	206,650	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	674	3,790	789,880	5	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,070	4,159	427,197	5	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316	3,100	0	30	0	16.00
17.00	01700	SOCIAL SERVICE	223	645	62,538	6	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,796	74,219	1,892,213	127	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	966	5,439	212,887	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,802	96,233	1,200,218	49	0	50.00
51.00	05100	RECOVERY ROOM	736	0	22,825	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,222	18,719	662,373	0	0	52.00
53.00	05300	ANESTHESIOLOGY	194	17,151	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,678	149,286	904,655	22	0	54.00
57.00	05700	CT SCAN	459	32,788	288	0	0	57.00
58.00	05800	MRI	726	440	66,944	0	0	58.00
60.00	06000	LABORATORY	2,206	42,817	938,862	19	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,085	11,548	371,573	11	0	65.00
66.00	06600	PHYSICAL THERAPY	12,448	11,457	1,284,544	37	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,327	11,795	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	848	4,699	93,350	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
76.97	07697	CARDIAC REHABILITATION	2,016	1,090	84,608	4	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	27,560	17,242	572,698	86	0	88.00
91.00	09100	EMERGENCY	5,476	21,311	978,686	18	0	91.00
91.01	09101	PRIORITY CARE CARLYLE	1,783	9,002	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	203,765	710,867	13,288,570	583	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	33,368	24,753	215,463	109	0	192.00
194.00	07950	LIFELINE	0	0	3,291	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	1,791,440	982,386	5,170,266	133,680	3,282,827	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.554579	1.335453	0.382775	193.179191	32,828.270000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,701	2,728	922,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000422	3.942197	9,223.040000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (SUPPLY EXP)	ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliatio n	ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,835,824					5.03
5.04	00570	ADMITTING	0	129,364,021				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	129,364,021			5.05
5.06	00590	ADMIN & GENERAL	28,975	0	0	-4,864,326	44,708,591	5.06
7.00	00700	OPERATION OF PLANT	75,963	0	0	0	2,164,350	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87	0	0	0	161,608	8.00
9.00	00900	HOUSEKEEPING	23,538	0	0	0	950,986	9.00
10.00	01000	DIETARY	4,833	0	0	0	208,557	10.00
11.00	01100	CAFETERIA	0	0	0	0	544,637	11.00
13.00	01300	NURSING ADMINISTRATION	1,693	0	0	0	1,141,149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,512	0	0	0	785,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	843,544	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	94,718	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,832	3,805,549	3,805,549	0	3,130,065	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	6,213	1,109,280	1,109,280	0	358,540	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	121,587	11,346,617	11,346,617	0	2,614,545	50.00
51.00	05100	RECOVERY ROOM	0	2,249,092	2,249,092	0	117,255	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	631	3,353,577	3,353,577	0	1,086,533	52.00
53.00	05300	ANESTHESIOLOGY	896	4,014,327	4,014,327	0	208,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,042	13,386,764	13,386,764	0	2,234,420	54.00
57.00	05700	CT SCAN	38,958	16,276,135	16,276,135	0	776,276	57.00
58.00	05800	MRI	4,111	4,326,507	4,326,507	0	338,530	58.00
60.00	06000	LABORATORY	164,065	26,730,421	26,730,421	0	3,220,741	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	82,771	531,095	531,095	0	111,546	63.00
65.00	06500	RESPIRATORY THERAPY	165	1,307,036	1,307,036	0	643,492	65.00
66.00	06600	PHYSICAL THERAPY	3,989	5,551,366	5,551,366	0	2,272,447	66.00
69.00	06900	ELECTROCARDIOLOGY	26,033	1,690,274	1,690,274	0	134,278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,499,501	2,591,158	2,591,158	0	1,834,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	562,763	1,125,525	1,125,525	0	639,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,450,023	10,930,122	10,930,122	0	1,935,032	73.00
76.97	07697	CARDIAC REHABILITATION	1,862	217,364	217,364	0	144,186	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	493,515	10,463,822	10,463,822	0	10,635,148	88.00
91.00	09100	EMERGENCY	5,872	8,318,423	8,318,423	0	1,747,054	91.00
91.01	09101	PRIORITY CARE CARLYLE	384	39,567	39,567	0	62,499	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,731,814	129,364,021	129,364,021	-4,864,326	41,140,249	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	104,010	0	0	0	3,563,791	192.00
194.00	07950	LIFELINE	0	0	0	0	4,551	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	318,758	420,029	4,189,054		4,864,326	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.065916	0.003247	0.032382		0.108801	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,060	32,167	958,577		523,794	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005803	0.000249	0.007410		0.011716	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	147,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	220,776			8.00
9.00	00900	HOUSEKEEPING	1,982	0	8,275		9.00
10.00	01000	DIETARY	3,377	0	0	13,744	10.00
11.00	01100	CAFETERIA	2,148	0	0	17,704	11.00
13.00	01300	NURSING ADMINISTRATION	674	0	50	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	1,070	0	75	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316	0	50	0	16.00
17.00	01700	SOCIAL SERVICE	223	0	25	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,796	97,145	1,750	13,345	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	966	0	100	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,802	38,972	950	0	50.00
51.00	05100	RECOVERY ROOM	736	0	150	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,222	0	100	0	52.00
53.00	05300	ANESTHESIOLOGY	194	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,678	29,046	450	60	54.00
57.00	05700	CT SCAN	459	0	50	0	57.00
58.00	05800	MRI	726	0	50	0	58.00
60.00	06000	LABORATORY	2,206	0	200	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,085	122	75	0	65.00
66.00	06600	PHYSICAL THERAPY	12,448	1,736	200	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	848	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	150	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,016	0	100	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	27,560	166	1,425	0	88.00
91.00	09100	EMERGENCY	5,476	36,903	700	339	91.00
91.01	09101	PRIORITY CARE CARLYLE	1,783	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,808	204,090	6,650	13,744	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	33,368	16,686	1,625	0	192.00
194.00	07950	LIFELINE	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,399,833	244,692	1,086,772	286,313	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.305872	1.108327	131.331964	20.831854	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	203,220	38,514	30,583	40,593	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.380796	0.174448	3.695831	2.953507	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	188,567					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	10,163	0	1,878,776			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	606		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	444	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,317	0	375	152	413	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	6,286	0	0	118	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,782	0	0	76	21	50.00
51.00	05100	RECOVERY ROOM	657	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,917	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	61	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	95	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	1,396,432	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	3,128	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	23,003	0	481,968	0	0	88.00
91.00	09100	EMERGENCY	22,407	0	1	86	10	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,660	0	1,878,776	606	444	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,907	0	0	0	0	192.00
194.00	07950	LIFELINE	0	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
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)	1,314,478	0	986,704	963,348	115,551	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.970880	0.000000	0.525184	1,589.683168	260.250000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,272	0	26,933	26,085	4,251	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.139324	0.000000	0.014335	43.044554	9.574324	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	ADMIN & GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
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	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
91.01	09101	PRIORITY CARE CARLYLE	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	LIFELINE	194.00
194.01	07951	DEVELOPMENT	194.01
194.02	07952	VACANT SPACE	194.02
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,200,713		5,200,713	0	5,200,713	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	668,735		668,735	743	669,478	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,811,338		3,811,338	0	3,811,338	50.00
51.00	05100	RECOVERY ROOM	167,448		167,448	0	167,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,443,832		1,443,832	0	1,443,832	52.00
53.00	05300	ANESTHESIOLOGY	233,891		233,891	0	233,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,789,440		2,789,440	0	2,789,440	54.00
57.00	05700	CT SCAN	875,401		875,401	0	875,401	57.00
58.00	05800	MRI	397,484		397,484	0	397,484	58.00
60.00	06000	LABORATORY	3,846,238		3,846,238	1,316	3,847,554	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	123,682		123,682	0	123,682	63.00
65.00	06500	RESPIRATORY THERAPY	777,140	0	777,140	12,312	789,452	65.00
66.00	06600	PHYSICAL THERAPY	2,840,700	0	2,840,700	21,120	2,861,820	66.00
69.00	06900	ELECTROCARDIOLOGY	149,610		149,610	0	149,610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,054,611		2,054,611	0	2,054,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	709,588		709,588	0	709,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,898,649		2,898,649	0	2,898,649	73.00
76.97	07697	CARDIAC REHABILITATION	233,098		233,098	0	233,098	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,941,944		12,941,944	0	12,941,944	88.00
91.00	09100	EMERGENCY	2,500,703		2,500,703	0	2,500,703	91.00
91.01	09101	PRIORITY CARE CARLYLE	98,372		98,372	28	98,400	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	723,643		723,643		723,643	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,486,260	0	45,486,260	35,519	45,521,779	200.00
201.00		Less Observation Beds	723,643		723,643		723,643	201.00
202.00		Total (see instructions)	44,762,617	0	44,762,617	35,519	44,798,136	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 1/31/2021 9:21 pm	
					Title XVIII		Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,098,398		3,098,398			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	1,109,280		1,109,280			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,308,722	10,037,895	11,346,617	0.335901	0.000000	50.00
51.00	05100	RECOVERY ROOM	158,104	2,090,988	2,249,092	0.074451	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,735,930	617,647	3,353,577	0.430535	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,825,914	2,188,413	4,014,327	0.058264	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	889,349	12,497,415	13,386,764	0.208373	0.000000	54.00
57.00	05700	CT SCAN	2,041,475	14,234,660	16,276,135	0.053784	0.000000	57.00
58.00	05800	MRI	140,162	4,186,345	4,326,507	0.091872	0.000000	58.00
60.00	06000	LABORATORY	3,732,602	22,997,819	26,730,421	0.143890	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	229,037	302,058	531,095	0.232881	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	681,630	625,406	1,307,036	0.594582	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	399,252	5,152,114	5,551,366	0.511712	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	198,202	1,492,072	1,690,274	0.088512	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	751,954	1,839,204	2,591,158	0.792932	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	433,600	691,925	1,125,525	0.630451	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,054,014	8,876,108	10,930,122	0.265198	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	217,364	217,364	1.072385	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,463,822	10,463,822			88.00
91.00	09100	EMERGENCY	1,099,624	7,218,799	8,318,423	0.300622	0.000000	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	39,567	39,567	2.486213	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	137,616	569,535	707,151	1.023322	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,024,865	106,339,156	129,364,021			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,024,865	106,339,156	129,364,021			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			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	0.335901			50.00
51.00	05100	RECOVERY ROOM	0.074451			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.430535			52.00
53.00	05300	ANESTHESIOLOGY	0.058264			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208373			54.00
57.00	05700	CT SCAN	0.053784			57.00
58.00	05800	MRI	0.091872			58.00
60.00	06000	LABORATORY	0.143939			60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.232881			63.00
65.00	06500	RESPIRATORY THERAPY	0.604002			65.00
66.00	06600	PHYSICAL THERAPY	0.515516			66.00
69.00	06900	ELECTROCARDIOLOGY	0.088512			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.792932			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630451			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265198			73.00
76.97	07697	CARDIAC REHABILITATION	1.072385			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.300622			91.00
91.01	09101	PRIORITY CARE CARLYLE	2.486921			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.023322			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,200,713		5,200,713	0	5,200,713	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	668,735		668,735	743	669,478	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,811,338		3,811,338	0	3,811,338	50.00
51.00	05100	RECOVERY ROOM	167,448		167,448	0	167,448	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,443,832		1,443,832	0	1,443,832	52.00
53.00	05300	ANESTHESIOLOGY	233,891		233,891	0	233,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,789,440		2,789,440	0	2,789,440	54.00
57.00	05700	CT SCAN	875,401		875,401	0	875,401	57.00
58.00	05800	MRI	397,484		397,484	0	397,484	58.00
60.00	06000	LABORATORY	3,846,238		3,846,238	1,316	3,847,554	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	123,682		123,682	0	123,682	63.00
65.00	06500	RESPIRATORY THERAPY	777,140	0	777,140	12,312	789,452	65.00
66.00	06600	PHYSICAL THERAPY	2,840,700	0	2,840,700	21,120	2,861,820	66.00
69.00	06900	ELECTROCARDIOLOGY	149,610		149,610	0	149,610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,054,611		2,054,611	0	2,054,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	709,588		709,588	0	709,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,898,649		2,898,649	0	2,898,649	73.00
76.97	07697	CARDIAC REHABILITATION	233,098		233,098	0	233,098	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,941,944		12,941,944	0	12,941,944	88.00
91.00	09100	EMERGENCY	2,500,703		2,500,703	0	2,500,703	91.00
91.01	09101	PRIORITY CARE CARLYLE	98,372		98,372	28	98,400	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	723,643		723,643		723,643	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,486,260	0	45,486,260	35,519	45,521,779	200.00
201.00		Less Observation Beds	723,643		723,643		723,643	201.00
202.00		Total (see instructions)	44,762,617	0	44,762,617	35,519	44,798,136	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

			Title XIX			Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,098,398		3,098,398		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
43.00	04300	NURSERY	1,109,280		1,109,280		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,722	10,037,895	11,346,617	0.335901	50.00
51.00	05100	RECOVERY ROOM	158,104	2,090,988	2,249,092	0.074451	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,735,930	617,647	3,353,577	0.430535	52.00
53.00	05300	ANESTHESIOLOGY	1,825,914	2,188,413	4,014,327	0.058264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	889,349	12,497,415	13,386,764	0.208373	54.00
57.00	05700	CT SCAN	2,041,475	14,234,660	16,276,135	0.053784	57.00
58.00	05800	MRI	140,162	4,186,345	4,326,507	0.091872	58.00
60.00	06000	LABORATORY	3,732,602	22,997,819	26,730,421	0.143890	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	229,037	302,058	531,095	0.232881	63.00
65.00	06500	RESPIRATORY THERAPY	681,630	625,406	1,307,036	0.594582	65.00
66.00	06600	PHYSICAL THERAPY	399,252	5,152,114	5,551,366	0.511712	66.00
69.00	06900	ELECTROCARDIOLOGY	198,202	1,492,072	1,690,274	0.088512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	751,954	1,839,204	2,591,158	0.792932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	433,600	691,925	1,125,525	0.630451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,054,014	8,876,108	10,930,122	0.265198	73.00
76.97	07697	CARDIAC REHABILITATION	0	217,364	217,364	1.072385	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,463,822	10,463,822	1.236828	88.00
91.00	09100	EMERGENCY	1,099,624	7,218,799	8,318,423	0.300622	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	39,567	39,567	2.486213	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	137,616	569,535	707,151	1.023322	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	23,024,865	106,339,156	129,364,021		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	23,024,865	106,339,156	129,364,021		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 1/31/2021 9:21 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
51.00	05100	RECOVERY ROOM	0.000000			51.00
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
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PRIORITY CARE CARLYLE	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		393,210	0	393,210	3,500	112.35	30.00
31.00	INTENSIVE CARE UNIT		0		0	0	0.00	31.00
43.00	NURSERY		35,482		35,482	1,141	31.10	43.00
200.00	Total (lines 30 through 199)		428,692		428,692	4,641		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,331	149,538				
31.00	INTENSIVE CARE UNIT		0	0				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		1,331	149,538				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	PPS	
						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	525,113	11,346,617	0.046279	600,595	27,795 50.00
51.00	05100	RECOVERY ROOM	25,878	2,249,092	0.011506	79,762	918 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,021	3,353,577	0.028931	5,164	149 52.00
53.00	05300	ANESTHESIOLOGY	57,831	4,014,327	0.014406	120,105	1,730 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	382,171	13,386,764	0.028548	524,193	14,965 54.00
57.00	05700	CT SCAN	182,079	16,276,135	0.011187	1,155,221	12,923 57.00
58.00	05800	MRI	44,563	4,326,507	0.010300	101,481	1,045 58.00
60.00	06000	LABORATORY	330,916	26,730,421	0.012380	1,824,731	22,590 60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	5,854	531,095	0.011023	54,003	595 63.00
65.00	06500	RESPIRATORY THERAPY	44,442	1,307,036	0.034002	383,527	13,041 65.00
66.00	06600	PHYSICAL THERAPY	200,822	5,551,366	0.036175	138,842	5,023 66.00
69.00	06900	ELECTROCARDIOLOGY	44,701	1,690,274	0.026446	130,568	3,453 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	66,380	2,591,158	0.025618	325,480	8,338 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,384	1,125,525	0.017222	291,700	5,024 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,372	10,930,122	0.012385	764,248	9,465 73.00
76.97	07697	CARDIAC REHABILITATION	23,910	217,364	0.110000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	614,518	10,463,822	0.058728	0	0 88.00
91.00	09100	EMERGENCY	180,594	8,318,423	0.021710	668,995	14,524 91.00
91.01	09101	PRIORITY CARE CARLYLE	63,672	39,567	1.609220	0	0 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	54,712	707,151	0.077370	64,788	5,013 92.00
200.00		Total (lines 50 through 199)	3,099,933	125,156,343		7,233,403	146,591 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0145		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/31/2021 9:21 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,500	0.00	1,331	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00		
43.00	04300	NURSERY		0	1,141	0.00	0	43.00		
200.00	Total (lines 30 through 199)			0	4,641		1,331	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
43.00	04300	NURSERY	0						43.00	
200.00	Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			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	11,346,617	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,249,092	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,353,577	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,014,327	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,386,764	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	16,276,135	0.000000	57.00
58.00	05800	MRI	0	0	0	4,326,507	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	26,730,421	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	531,095	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,307,036	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,551,366	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,690,274	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	2,591,158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,125,525	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,930,122	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	217,364	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	10,463,822	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	8,318,423	0.000000	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	39,567	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	707,151	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,156,343		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
1/31/2021 9:21 pm

				Title XVIII		Hospital	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	600,595	0	2,637,792	0
51.00	05100	RECOVERY ROOM		0.000000	79,762	0	545,183	0
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	5,164	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	120,105	0	563,898	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	524,193	0	3,490,030	0
57.00	05700	CT SCAN		0.000000	1,155,221	0	5,691,905	0
58.00	05800	MRI		0.000000	101,481	0	1,309,197	0
60.00	06000	LABORATORY		0.000000	1,824,731	0	2,765,166	0
63.00	06300	BLOOD STORING PROCESSING & TRA		0.000000	54,003	0	25,749	0
65.00	06500	RESPIRATORY THERAPY		0.000000	383,527	0	245,440	0
66.00	06600	PHYSICAL THERAPY		0.000000	138,842	0	801,981	0
69.00	06900	ELECTROCARDIOLOGY		0.000000	130,568	0	586,467	0
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0.000000	325,480	0	393,755	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	291,700	0	167,475	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	764,248	0	4,418,246	0
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	108,007	0
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0
91.00	09100	EMERGENCY		0.000000	668,995	0	2,085,051	0
91.01	09101	PRIORITY CARE CARLYLE		0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0.000000	64,788	0	300,391	0
200.00		Total (lines 50 through 199)			7,233,403	0	26,135,733	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/31/2021 9:21 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.335901	2,637,792	0	0	886,037	50.00
51.00	05100	RECOVERY ROOM	0.074451	545,183	0	0	40,589	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.430535	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058264	563,898	0	0	32,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208373	3,490,030	0	0	727,228	54.00
57.00	05700	CT SCAN	0.053784	5,691,905	0	0	306,133	57.00
58.00	05800	MRI	0.091872	1,309,197	0	0	120,279	58.00
60.00	06000	LABORATORY	0.143890	2,765,166	0	0	397,880	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.232881	25,749	0	0	5,996	63.00
65.00	06500	RESPIRATORY THERAPY	0.594582	245,440	0	0	145,934	65.00
66.00	06600	PHYSICAL THERAPY	0.511712	801,981	0	0	410,383	66.00
69.00	06900	ELECTROCARDIOLOGY	0.088512	586,467	0	0	51,909	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.792932	393,755	0	0	312,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630451	167,475	0	0	105,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265198	4,418,246	0	4,200	1,171,710	73.00
76.97	07697	CARDIAC REHABILITATION	1.072385	108,007	0	0	115,825	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.300622	2,085,051	0	51	626,812	91.00
91.01	09101	PRIORITY CARE CARLYLE	2.486213	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.023322	300,391	0	0	307,397	92.00
200.00		Subtotal (see instructions)		26,135,733	0	4,251	5,764,773	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		26,135,733	0	4,251	5,764,773	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/31/2021 9:21 pm

				Title XVIII	Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,114		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	15		91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	1,129		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,129		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,500	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)		3,013	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		51	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)		237	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,331	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)		34	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)		157	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		5,200,713	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)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,200,713	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)		5,200,713	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,485.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,977,760	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)		1,977,760	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,899,669
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,877,429
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					149,538
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					146,591
52.00	Total Program excludable cost (sum of lines 50 and 51)					296,129
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,581,300
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					487
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,485.92
89.00	Observation bed cost (line 87 x line 88) (see instructions)					723,643

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	393,210	5,200,713	0.075607	723,643	54,712	90.00
91.00 Nursing School cost	0	5,200,713	0.000000	723,643	0	91.00
92.00 Allied health cost	0	5,200,713	0.000000	723,643	0	92.00
93.00 All other Medical Education	0	5,200,713	0.000000	723,643	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/31/2021 9:21 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,210,400		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	0.335901	600,595	201,740	50.00
51.00	05100	RECOVERY ROOM	0.074451	79,762	5,938	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.430535	5,164	2,223	52.00
53.00	05300	ANESTHESIOLOGY	0.058264	120,105	6,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208373	524,193	109,228	54.00
57.00	05700	CT SCAN	0.053784	1,155,221	62,132	57.00
58.00	05800	MRI	0.091872	101,481	9,323	58.00
60.00	06000	LABORATORY	0.143939	1,824,731	262,650	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.232881	54,003	12,576	63.00
65.00	06500	RESPIRATORY THERAPY	0.604002	383,527	231,651	65.00
66.00	06600	PHYSICAL THERAPY	0.515516	138,842	71,575	66.00
69.00	06900	ELECTROCARDIOLOGY	0.088512	130,568	11,557	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.792932	325,480	258,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630451	291,700	183,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265198	764,248	202,677	73.00
76.97	07697	CARDIAC REHABILITATION	1.072385	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.300622	668,995	201,115	91.00
91.01	09101	PRIORITY CARE CARLYLE	2.486921	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.023322	64,788	66,299	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,233,403	1,899,669	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)		7,233,403		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/31/2021 9:21 pm	
			Component CCN:14-U145	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		0		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	0.335901	2,857	960	50.00
51.00	05100	RECOVERY ROOM	0.074451	1,076	80	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.430535	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058264	1,412	82	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208373	6,497	1,354	54.00
57.00	05700	CT SCAN	0.053784	17,277	929	57.00
58.00	05800	MRI	0.091872	0	0	58.00
60.00	06000	LABORATORY	0.143939	51,692	7,440	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.232881	1,182	275	63.00
65.00	06500	RESPIRATORY THERAPY	0.604002	19,710	11,905	65.00
66.00	06600	PHYSICAL THERAPY	0.515516	91,005	46,915	66.00
69.00	06900	ELECTROCARDIOLOGY	0.088512	1,121	99	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.792932	9,406	7,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265198	53,625	14,221	73.00
76.97	07697	CARDIAC REHABILITATION	1.072385	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.300622	1,753	527	91.00
91.01	09101	PRIORITY CARE CARLYLE	2.486921	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.023322	1,475	1,509	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		260,088	93,754	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)		260,088		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		802,109	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,904,323	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		2,325	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		43.75	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.55	31.00
32.00	Sum of lines 30 and 31		23.22	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.37	33.00
34.00	Disproportionate share adjustment (see instructions)		56,632	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/31/2021 9:21 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)		0.000058144	0.000088404	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		481,017	738,225	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		121,243	552,660	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		673,903		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,439,292		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			3,439,292	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			215,998	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,655,290	59.00
60.00	Primary payer payments			1,092	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,654,198	61.00
62.00	Deductibles billed to program beneficiaries			388,476	62.00
63.00	Coinsurance billed to program beneficiaries			2,816	63.00
64.00	Allowable bad debts (see instructions)			65,820	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			42,783	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			47,583	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,305,689	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			22,596	70.93
70.94	HRR adjustment amount (see instructions)			-80	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	194,565	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2020	526,539	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,049,309	71.00
71.01	Sequestration adjustment (see instructions)		67,623	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		3,879,269	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		102,417	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		327,066	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	802,109	0	802,109		802,109
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,904,323	0		1,904,323	1,904,323
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,325	0	2,325		2,325
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0837	0.0837	0.0837	0.0837	
11.00	Disproportionate share adjustment (see instructions)	34.00	56,632	0	16,784	39,848	56,632
11.01	Uncompensated care payments	36.00	673,903	0	121,243	552,660	673,903
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	3,439,292	0	942,461	2,496,831	3,439,292
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,439,292	0	942,461	2,496,831	3,439,292

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	215,998	0	65,096	150,902	215,998
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,007,557	2,647,733	3,655,290
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	215,710	0	64,808	150,902	215,710
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	288	0	288	0	288
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	215,998	0	65,096	150,902	215,998
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.193106	0.198864	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			194,565		194,565
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				526,539	526,539
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	802,109	802,109		802,109	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,904,323		1,904,323	1,904,323	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,325	2,325		2,325	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0837	0.0837	0.0837		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	56,632	16,784	39,848	56,632	11.00
11.01	Uncompensated care payments	36.00	673,903	121,243	552,661	673,904	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,439,292	942,461	2,496,831	3,439,292	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,439,292	942,461	2,496,831	3,439,292	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	215,998	65,096	150,902	215,998	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,007,557	2,647,733	3,655,290	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	215,710	64,808	150,902	215,710	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	288	288	0	288	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	215,998	65,096	150,902	215,998	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	194,565	194,565		194,565	28.00
29.00	Low volume adjustment on or after October 1	70.97	526,539		526,539	526,539	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	22,596	10,765	11,831	22,596	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-80	-80	0	-80	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,129	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,764,773	2.00
3.00	OPPS payments		4,011,824	3.00
4.00	Outlier payment (see instructions)		1,976	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)		1,129	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,251	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)		4,251	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)		4,251	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,122	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)		1,129	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)		4,013,800	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		810,042	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)		3,204,887	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)		3,204,887	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,204,887	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)		102,666	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		66,733	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		78,170	36.00
37.00	Subtotal (see instructions)		3,271,620	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,271,620	40.00
40.01	Sequestration adjustment (see instructions)		54,636	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,173,781	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		43,203	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/31/2021 9:21 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,856,872		3,146,980	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	06/30/2020	22,397	06/30/2020	26,801	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		22,397		26,801	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,879,269		3,173,781	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	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		102,417		43,203	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,981,686		3,216,984	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0145

Period:

Worksheet E-1

Component CCN: 14-U145

From 07/01/2019

Part I

To 06/30/2020

Date/Time Prepared:

1/31/2021 9:21 pm

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		106,447		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		106,447		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		342		0	6.02	
7.00	Total Medicare program liability (see instructions)		106,105		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-0145

Period:

Worksheet E-2

Component CCN:14-U145

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

1/31/2021 9:21 pm

		Title XVIII	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)		115,217	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)		0	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		191	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)		115,217	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		115,217	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		115,217	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		7,310	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		107,907	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)		107,907	0	19.00
19.01	Sequestration adjustment (see instructions)		1,802	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		106,447	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, 20, and 21)		-342	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
1/31/2021 9:21 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	4,388,796	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	19,855,402	0	0	0	4.00
5.00	Other receivable	186,217	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,538,606	0	0	0	6.00
7.00	Inventory	848,807	0	0	0	7.00
8.00	Prepaid expenses	113,345	0	0	0	8.00
9.00	Other current assets	4,338,825	0	0	0	9.00
10.00	Due from other funds	-302,374	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,890,412	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,704,210	0	0	0	12.00
13.00	Land improvements	4,755,874	0	0	0	13.00
14.00	Accumulated depreciation	-3,346,150	0	0	0	14.00
15.00	Buildings	30,162,842	0	0	0	15.00
16.00	Accumulated depreciation	-14,044,821	0	0	0	16.00
17.00	Leasehold improvements	267,301	0	0	0	17.00
18.00	Accumulated depreciation	-267,301	0	0	0	18.00
19.00	Fixed equipment	14,682,190	0	0	0	19.00
20.00	Accumulated depreciation	-12,796,448	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	26,923,439	0	0	0	23.00
24.00	Accumulated depreciation	-21,357,214	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)	26,683,922	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	132,906,315	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,233,831	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	142,140,146	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	185,714,480	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,369,723	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,473,017	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,529,723	0	0	0	40.00
41.00	Deferred income	6,775,070	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	467,567	0	0	0	43.00
44.00	Other current liabilities	4,370,258	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,985,358	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	12,174,986	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,021,546	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,196,532	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,181,890	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	140,532,590	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	140,532,590	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	185,714,480	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
1/31/2021 9:21 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		145,120,516		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,349,613				2.00
3.00	Total (sum of line 1 and line 2)		143,770,903		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)		143,770,903		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET TRANSFERS	3,238,313		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)		3,238,313		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		140,532,590		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	NET TRANSFERS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/31/2021 9:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,320,157		4,320,157	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,320,157		4,320,157	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)	4,320,157		4,320,157	17.00
18.00	Ancillary services	18,025,873	90,794,132	108,820,005	18.00
19.00	Outpatient services	1,245,587	7,950,261	9,195,848	19.00
20.00	RURAL HEALTH CLINIC	0	10,463,822	10,463,822	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS	42,483	540,263	582,746	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,634,100	109,748,478	133,382,578	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,402,742		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)		56,402,742		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
1/31/2021 9:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	133,382,578	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,306,500	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,076,078	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,402,742	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,326,664	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	42,720	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	40	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	440,858	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	-1,114,161	24.00
24.50	COVID-19 PHE Funding	4,607,594	24.50
25.00	Total other income (sum of lines 6-24)	3,977,051	25.00
26.00	Total (line 5 plus line 25)	-1,349,613	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)	-1,349,613	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0145	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 1/31/2021 9:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		215,710	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		288	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		9.07	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		215,998	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0145

Period:

Worksheet M-1

Component CCN: 14-8503

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/31/2021 9:21 pm

						RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	0	2,867,592	2,867,592	0	2,867,592	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	91,146	1,839,282	1,930,428	0	1,930,428	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	10,929	700,470	711,399	0	711,399	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	79,108	79,108	0	79,108	9.00		
10.00	Subtotal (sum of lines 1 through 9)	102,075	5,486,452	5,588,527	0	5,588,527	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	87,257	87,257	0	87,257	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	484,801	484,801	0	484,801	19.00		
20.00	Allowable GME Costs	0	0	0	0	0	20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	572,058	572,058	0	572,058	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	102,075	6,058,510	6,160,585	0	6,160,585	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	59,336	59,336	0	59,336	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	0	0	0	0	0	27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	59,336	59,336	0	59,336	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	238,450	238,450	-33,166	205,284	29.00		
30.00	Administrative Costs	470,623	2,307,615	2,778,238	-84,160	2,694,078	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	470,623	2,546,065	3,016,688	-117,326	2,899,362	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	572,698	8,663,911	9,236,609	-117,326	9,119,283	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0145

Period:

Worksheet M-1

Component CCN: 14-8503

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/31/2021 9:21 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	2,867,592	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	1,930,428	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	711,399	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	79,108	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	5,588,527	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	87,257	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	484,801	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	572,058	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	6,160,585	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	59,336	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	59,336	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	205,284	29.00
30.00	Administrative Costs	643,462	3,337,540	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	643,462	3,542,824	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	643,462	9,762,745	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0145

Period:

Worksheet M-2

Component CCN: 14-8503

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/31/2021 9:21 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	7.06	26,307	4,200	29,652		1.00
2.00	Physician Assistant	1.35	4,862	2,100	2,835		2.00
3.00	Nurse Practitioner	8.10	18,204	2,100	17,010		3.00
4.00	Subtotal (sum of lines 1 through 3)	16.51	49,373		49,497	49,497	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)	16.51	49,373			49,497	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)					6,160,585	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					59,336	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					6,219,921	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990460	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,542,824	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,179,199	15.00
16.00	Total overhead (sum of lines 14 and 15)					6,722,023	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					6,722,023	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					6,657,895	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					12,818,480	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0145 Component CCN: 14-8503	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 1/31/2021 9:21 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)			12,818,480	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			718,078	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			12,100,402	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			49,497	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)			49,497	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			244.47	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			244.47	244.47	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			7,235	4,958	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			1,768,740	1,212,082	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	2,980,822	16.00
16.01	Total program charges (see instructions)(from contractor's records)				2,232,982	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				1,278	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				1,705	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				2,185,375	16.04
16.05	Total program cost (see instructions)			0	2,187,080	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				247,398	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				396,699	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				2,187,080	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				151,274	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				2,338,354	22.00
23.00	Allowable bad debts (see instructions)				64,655	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				42,026	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				64,471	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				2,380,380	26.00
26.01	Sequestration adjustment (see instructions)				39,752	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,873,130	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)				467,498	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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-0145 Component CCN:14-8503	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/31/2021 9:21 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		5,588,527	5,588,527	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.006008	0.014074	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		33,576	78,653	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		171,314	61,567	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		204,890	140,220	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		6,160,585	6,160,585	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		6,657,895	6,657,895	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.033258	0.022761	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		221,428	151,540	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		426,318	291,760	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1,238	2,900	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		344.36	100.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		245	665	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		84,368	66,906	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			718,078	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			151,274	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0145 Component CCN: 14-8503	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/31/2021 9:21 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,873,130	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,873,130		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		467,498		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		2,340,628		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00