

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/9/2021 8:08 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/9/2021	Time: 8:08 am
	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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RICHLAND MEMORIAL HOSPITAL (14-0147) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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	41,552	6,514	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	2,834	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	6,839		0	9.00
10.00	RURAL HEALTH CLINIC I	0		234,192		0	10.00
10.01	RURAL HEALTH CLINIC II	0		334,874		0	10.01
10.02	RURAL HEALTH CLINIC III	0		255,963		0	10.02
200.00	Total	0	44,386	838,382	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: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 8:08 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 800 EAST LOCUST			PO Box:				1.00		
2.00	City: OLNEY			State: IL		Zip Code: 62450-2958		County: RICHLAND		
		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		RICHLAND MEMORIAL HOSPITAL	140147	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF		RICHLAND MEMORIAL HOSPITAL PSYCH	14S147	99914	4	07/01/1966	N	P	P
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		RICHLAND MEMORIAL HOSPITAL SWING BED	14U147	99914		11/13/2003	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		RICHLAND MEMORIAL HOSPITAL SNF	145580	99914		11/05/1987	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		RICHLAND MEMORIAL HOSPITAL HHA	147187	99914		05/01/1980	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		RICHLAND MEMORIAL HOSPITAL HOSPICE	141542	99914		04/23/1991			
15.00	Hospital-Based Health Clinic - RHC		RICHLAND MEMORIAL HOSPITAL WEST SALE	148548	99914		12/04/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		RICHLAND MEMORIAL HOSPITAL FAM PRAC	148586	99914		03/14/2018	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		RICHLAND MEMORIAL HOSPITAL PRIMARY C	148584	99914		03/15/2018	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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)					N	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		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.					3	N		23.00	

Worksheet S-2
Part I
Date/Time Prepared:
7/9/2021 8:08 am

MCRIF32 - 16.10.172.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 8:08 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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			
64.00	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. 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)					0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
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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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	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.				Y	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)				N N 0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 8:08 am
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		1.00	
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	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.	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	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	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	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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	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	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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

	Physical	Occupational	Speech	Respiratory	
	1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	109.00

		1.00		
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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
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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	181,204	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 8:08 am
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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	
						2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/9/2021 8:08 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	05/25/2021	Y	05/25/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/9/2021 8:08 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCAS	MORTON		41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-902-6326	LUCAS.MORTON@CARLE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR-FINANCE	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/9/2021 8:08 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	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)		39	14,235	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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)		47	17,155	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/9/2021 8:08 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,628	85	3,127			1.00
2.00	HMO and other (see instructions)	70	827				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	1,482	0	1,482			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)	3,110	85	4,609			7.00
8.00	INTENSIVE CARE UNIT	356	21	583			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		80	244			13.00
14.00	Total (see instructions)	3,466	186	5,436	0.00	323.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	4,773	0.00	18.88	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	2,975	0.00	4.08	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	1.67	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	2,309	0	5,762	0.00	10.01	26.00
26.01	RURAL HEALTH CLINIC II	2,209	0	5,222	0.00	6.88	26.01
26.02	RURAL HEALTH CLINIC III	1,010	0	10,508	0.00	18.87	26.02
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	383.44	27.00
28.00	Observation Bed Days		0	972			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	10			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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/9/2021 8:08 am

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	538	77	1,218	1.00
2.00 HMO and other (see instructions)			286	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	538	77	1,218	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/9/2021 8:08 am

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	23,192,223	-343,099	22,849,124	797,554.69	28.65
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		954,829	0	954,829	8,336.00	114.54
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	942,454	0	942,454	39,279.52	23.99
10.00	Excluded area salaries (see instructions)		2,745,250	-514,693	2,230,557	91,972.59	24.25
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		4,809,539	0	4,809,539	139,358.47	34.51
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,814,147	0	4,814,147		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		950,232	0	950,232		
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		0	0	0		
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)		1,530,217	0	1,530,217		
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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/9/2021 8:08 am

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	48,116	0	48,116	1,354.75	35.52	26.00
27.00	Administrative & General	5.00	2,450,949	-20,848	2,430,101	101,073.30	24.04	27.00
28.00	Administrative & General under contract (see inst.)		466,495	0	466,495	2,815.19	165.71	28.00
29.00	Maintenance & Repairs	6.00	838,372	0	838,372	33,698.60	24.88	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	278,612	0	278,612	14,696.65	18.96	31.00
32.00	Housekeeping	9.00	537,477	0	537,477	35,868.78	14.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	657,091	-507,298	149,793	9,291.67	16.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	507,298	507,298	31,467.70	16.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,273,596	-342	1,273,254	33,624.76	37.87	38.00
39.00	Central Services and Supply	14.00	85,082	0	85,082	4,886.30	17.41	39.00
40.00	Pharmacy	15.00	877,972	-14,679	863,293	17,876.58	48.29	40.00
41.00	Medical Records & Medical Records Library	16.00	4,007	0	4,007	242.75	16.51	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/9/2021 8:08 am

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	22,703,889	-343,099	22,360,790	792,033.88	28.23	1.00
2.00	Excluded area salaries (see instructions)	3,687,704	-514,693	3,173,011	131,252.11	24.17	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,016,185	171,594	19,187,779	660,781.77	29.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,809,539	0	4,809,539	139,358.47	34.51	4.00
5.00	Subtotal wage-related costs (see inst.)	6,344,364	0	6,344,364	0.00	33.06	5.00
6.00	Total (sum of lines 3 thru 5)	30,170,088	171,594	30,341,682	800,140.24	37.92	6.00
7.00	Total overhead cost (see instructions)	7,517,769	-35,869	7,481,900	286,897.03	26.08	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/9/2021 8:08 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,515,780	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)		0	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)		2,094,416	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	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)		85,416	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		174,940	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		1,799,605	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		41,792	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		52,430	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,764,379	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/9/2021 8:08 am

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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-7187	Period: From 01/01/2020 To 12/31/2020	Worksheet S-4 Date/Time Prepared: 7/9/2021 8:08 am		
					Home Health Agency I	PPS		
					1.00			
0.00	County						0.00	
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	0	0	0	0	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00	
		Enter the number of hours in your normal work week			Number of Employees (Full Time Equivalent)			
					Staff	Contract	Total	
		0			1.00	2.00	3.00	
		HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	3.00	
4.00	Director(s) and Assistant Director(s)				0.00	0.00	4.00	
5.00	Other Administrative Personnel				0.00	0.00	5.00	
6.00	Direct Nursing Service				0.00	0.00	6.00	
7.00	Nursing Supervisor				0.00	0.00	7.00	
8.00	Physical Therapy Service				0.00	0.00	8.00	
9.00	Physical Therapy Supervisor				0.00	0.00	9.00	
10.00	Occupational Therapy Service				0.00	0.00	10.00	
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00	
12.00	Speech Pathology Service				0.00	0.00	12.00	
13.00	Speech Pathology Supervisor				0.00	0.00	13.00	
14.00	Medical Social Service				0.00	0.00	14.00	
15.00	Medical Social Service Supervisor				0.00	0.00	15.00	
16.00	Home Health Aide				0.00	0.00	16.00	
17.00	Home Health Aide Supervisor				0.00	0.00	17.00	
18.00	Other (specify)				0.00	0.00	18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914					20.00	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers					
		1.00	2.00					3.00
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	780	218	25	36	1,059	21.00	
22.00	Skilled Nursing Visit Charges	220,303	61,572	7,061	10,168	299,104	22.00	
23.00	Physical Therapy Visits	537	103	7	10	657	23.00	
24.00	Physical Therapy Visit Charges	150,721	29,180	1,983	2,833	184,717	24.00	
25.00	Occupational Therapy Visits	62	91	2	6	161	25.00	
26.00	Occupational Therapy Visit Charges	17,511	25,702	565	1,695	45,473	26.00	
27.00	Speech Pathology Visits	22	5	0	0	27	27.00	
28.00	Speech Pathology Visit Charges	6,213	1,412	0	0	7,625	28.00	
29.00	Medical Social Service Visits	7	1	0	1	9	29.00	
30.00	Medical Social Service Visit Charges	2,746	392	0	392	3,530	30.00	
31.00	Home Health Aide Visits	80	70	0	9	159	31.00	
32.00	Home Health Aide Visit Charges	13,154	11,510	0	1,480	26,144	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,488	488	34	62	2,072	33.00	
34.00	Other Charges	23,568	11,970	3,816	1,832	41,186	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	434,216	141,738	13,425	18,400	607,779	35.00	
36.00	Total Number of Episodes (standard/non outlier)	135		20	11	166	36.00	
37.00	Total Number of Outlier Episodes		20		0	20	37.00	
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8548		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 7/9/2021 8:08 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			100 SOUTH MAIN			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			WEST SALEM		ILLINOIS 62476		2.00	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?							12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County							2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2020 To 12/31/2020	Worksheet S-8 Date/Time Prepared: 7/9/2021 8:08 am	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8586		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 7/9/2021 8:08 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				800 LOCUST ST				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				OLNEY IL 62450				2.00
								1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
						1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00
						1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?								12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				RICHLAND				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0147

Period:

Worksheet S-8

Component CCN: 14-8586

From 01/01/2020
To 12/31/2020

Date/Time Prepared:

7/9/2021 8:08 am

RHC II

Cost

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

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0147 Component CCN: 14-8584		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/9/2021 8:08 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	800 LOCUST ST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	OLNEY IL		62450	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	from
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC			11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	RICHLAND		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC			11.00	

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147	Period: From 01/01/2020	Worksheet S-8
			Component CCN: 14-8584	To 12/31/2020	Date/Time Prepared: 7/9/2021 8:08 am
			RHC III		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
					14.00
			Facility hours of operations (1)		
11.00	CLINIC				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0147

Period:

Worksheet S-9

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020PARTS I THROUGH IV
Date/Time Prepared:
7/9/2021 8:08 am

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,687	0	0	1,687	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	1,687	0	0	1,687	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-10

Date/Time Prepared:
7/9/2021 8:08 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.299604	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	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)		0	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)		0	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)	1,406,907	516,699	1,923,606
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	421,515	516,699	938,214
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	421,515	516,699	938,214
				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)		814,722	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		156,188	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		240,289	27.01
28.00	Non-Medicare bad debt expense (see instructions)		574,433	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		256,203	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,194,417	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,194,417	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		750,249	750,249	470,066	1,220,315	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	-7,774	-7,774	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	48,116	199,133	247,249	0	247,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,450,949	14,145,142	16,596,091	-462,292	16,133,799	5.00
6.00	00600	MAINTENANCE & REPAIRS	838,372	763,262	1,601,634	0	1,601,634	6.00
7.00	00700	OPERATION OF PLANT	0	498,308	498,308	0	498,308	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	278,612	251,487	530,099	0	530,099	8.00
9.00	00900	HOUSEKEEPING	537,477	346,666	884,143	0	884,143	9.00
10.00	01000	DIETARY	657,091	1,000,962	1,658,053	-1,280,077	377,976	10.00
11.00	01100	CAFETERIA	0	0	0	1,280,077	1,280,077	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,273,596	621,882	1,895,478	0	1,895,478	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	85,082	164,100	249,182	0	249,182	14.00
15.00	01500	PHARMACY	877,972	3,120,907	3,998,879	-1,479,690	2,519,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,007	54,075	58,082	0	58,082	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,495,766	990,284	3,486,050	-292,665	3,193,385	30.00
31.00	03100	INTENSIVE CARE UNIT	646,425	277,158	923,583	-42,721	880,862	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	285,881	105,817	391,698	-5,250	386,448	43.00
44.00	04400	SKILLED NURSING FACILITY	942,454	340,546	1,283,000	0	1,283,000	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	641,349	1,337,545	1,978,894	-651,262	1,327,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	85,438	85,438	52.00
53.00	05300	ANESTHESIOLOGY	954,829	322,742	1,277,571	0	1,277,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	712,272	459,046	1,171,318	0	1,171,318	54.00
56.00	05600	RADIOISOTOPE	98,077	212,827	310,904	0	310,904	56.00
57.00	05700	CT SCAN	116,165	207,483	323,648	0	323,648	57.00
58.00	05800	MRI	56,801	355,116	411,917	0	411,917	58.00
60.00	06000	LABORATORY	1,145,901	1,819,580	2,965,481	0	2,965,481	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	433,795	191,884	625,679	0	625,679	65.00
66.00	06600	PHYSICAL THERAPY	1,578,862	515,638	2,094,500	0	2,094,500	66.00
68.00	06800	SPEECH PATHOLOGY	184,359	258,829	443,188	0	443,188	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,476	24,476	0	24,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	801,420	801,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	105,040	105,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,479,690	1,479,690	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	405,117	679,470	1,084,587	151,419	1,236,006	88.00
88.01	08801	RURAL HEALTH CLINIC II	458,400	867,955	1,326,355	138,556	1,464,911	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,240,391	862,535	2,102,926	180,483	2,283,409	88.02
91.00	09100	EMERGENCY	998,855	2,750,587	3,749,442	0	3,749,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,122	2,122	0	2,122	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	210,954	132,814	343,768	0	343,768	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	90,005	143,033	233,038	0	233,038	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,747,932	34,773,660	55,521,592	470,458	55,992,050	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,444,291	3,244,719	5,689,010	-470,458	5,218,552	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	80	80	0	80	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.03	07951	CONTRACTED RETAIL RX	0	61,197	61,197	0	61,197	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	23,192,223	38,079,656	61,271,879	0	61,271,879	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-123,307	1,097,008	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	-7,774	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-598,811	-351,562	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-481,134	15,652,665	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,601,634	6.00
7.00	00700	OPERATION OF PLANT	628,589	1,126,897	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-106,467	423,632	8.00
9.00	00900	HOUSEKEEPING	0	884,143	9.00
10.00	01000	DIETARY	0	377,976	10.00
11.00	01100	CAFETERIA	-206,618	1,073,459	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-342	1,895,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,510	376,692	14.00
15.00	01500	PHARMACY	0	2,519,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213,753	271,835	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,193,385	30.00
31.00	03100	INTENSIVE CARE UNIT	0	880,862	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	386,448	43.00
44.00	04400	SKILLED NURSING FACILITY	-54,630	1,228,370	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,327,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	85,438	52.00
53.00	05300	ANESTHESIOLOGY	-954,829	322,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,171,318	54.00
56.00	05600	RADIOISOTOPE	0	310,904	56.00
57.00	05700	CT SCAN	0	323,648	57.00
58.00	05800	MRI	0	411,917	58.00
60.00	06000	LABORATORY	-103,454	2,862,027	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	625,679	65.00
66.00	06600	PHYSICAL THERAPY	-100	2,094,400	66.00
68.00	06800	SPEECH PATHOLOGY	-567	442,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	801,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	105,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,479,690	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	22,970	1,258,976	88.00
88.01	08801	RURAL HEALTH CLINIC II	23,268	1,488,179	88.01
88.02	08802	RURAL HEALTH CLINIC III	25,322	2,308,731	88.02
91.00	09100	EMERGENCY	-2,231,054	1,518,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	2,122	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	343,768	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	233,038	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,819,901	52,172,149	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,218,552	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	80	194.00
194.01	07952	MEMORY DISORDER	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	61,197	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,819,901	57,451,978	200.00

RECLASSIFICATIONS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/9/2021 8:08 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - RECLASS CAFETERIA				1.00
	CAFETERIA	11.00	507,298	772,779	
	0		507,298	772,779	
1.00	B - INTEREST EXPENSE				1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	301,139	
	0		0	301,139	
1.00	C - OTHER CAPITAL RELATED				1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	104,052	
	2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	
1.00					2.00
	0		0	168,927	
	D - RECLASS IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	105,040	1.00
	0		0	105,040	
	E - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	801,420	1.00
	2.00	0.00	0	0	
	3.00	0.00	0	0	
4.00	0	0.00	0	0	4.00
	0		0	801,420	
	F - RECLASS DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,479,690	1.00
	0		0	1,479,690	
	G - LABOR AND DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	65,761	19,677	1.00
	TOTALS		65,761	19,677	
	H - CONTRACT LABOR				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,848	1.00
2.00	NURSING ADMINISTRATION	13.00	0	342	2.00
3.00	PHARMACY	15.00	0	14,679	3.00
4.00	LABORATORY	60.00	0	103,454	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	203,776	5.00
	TOTALS		0	343,099	
I - PHYSICIAN PRACTICE MANAGEMENT					
1.00	RURAL HEALTH CLINIC	88.00	100,070	51,349	1.00
2.00	RURAL HEALTH CLINIC II	88.01	91,569	46,987	2.00
3.00	RURAL HEALTH CLINIC III	88.02	119,278	61,205	3.00
	TOTALS		310,917	159,541	
500.00	Grand Total: Increases		883,976	4,151,312	500.00

RECLASSIFICATIONS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/9/2021 8:08 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	507,298	772,779	0		1.00
	0		507,298	772,779			
	B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	301,139	11		1.00
	0		0	301,139			
	C - OTHER CAPITAL RELATED						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,774	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	161,153	13		2.00
	0		0	168,927			
	D - RECLASS IMPLANTS						
1.00	OPERATING ROOM	50.00	0	105,040	0		1.00
	0		0	105,040			
	E - RECLASS MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	207,227	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	42,721	0		2.00
3.00	NURSERY	43.00	0	5,250	0		3.00
4.00	OPERATING ROOM	50.00	0	546,222	0		4.00
	0		0	801,420			
	F - RECLASS DRUGS						
1.00	PHARMACY	15.00	0	1,479,690	0		1.00
	0		0	1,479,690			
	G - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	65,761	19,677	0		1.00
	TOTALS		65,761	19,677			
	H - CONTRACT LABOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	20,848	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	342	0	0		2.00
3.00	PHARMACY	15.00	14,679	0	0		3.00
4.00	LABORATORY	60.00	103,454	0	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	203,776	0	0		5.00
	TOTALS		343,099	0			
	I - PHYSICIAN PRACTICE MANAGEMENT						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	310,917	159,541	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		310,917	159,541			
500.00	Grand Total: Decreases		1,227,075	3,808,213			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/9/2021 8:08 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,005,119	0	0	0	0	1.00	
2.00	Land Improvements	487,120	62,756	0	62,756	0	2.00	
3.00	Buildings and Fixtures	19,973,590	3,532,587	0	3,532,587	0	3.00	
4.00	Building Improvements	9,558,256	0	0	0	0	4.00	
5.00	Fixed Equipment	2,355,173	0	0	0	0	5.00	
6.00	Movable Equipment	23,578,502	1,740,067	0	1,740,067	0	6.00	
7.00	HIT designated Assets	789,578	0	0	0	789,578	7.00	
8.00	Subtotal (sum of lines 1-7)	57,747,338	5,335,410	0	5,335,410	789,578	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	57,747,338	5,335,410	0	5,335,410	789,578	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,005,119	0				1.00	
2.00	Land Improvements	549,876	0				2.00	
3.00	Buildings and Fixtures	23,506,177	0				3.00	
4.00	Building Improvements	9,558,256	0				4.00	
5.00	Fixed Equipment	2,355,173	0				5.00	
6.00	Movable Equipment	25,318,569	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	62,293,170	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	62,293,170	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	750,249	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)	750,249	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	750,249				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	750,249				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,974,601	0	36,974,601	0.593558	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,318,569	0	25,318,569	0.406442	0	2.00
3.00	Total (sum of lines 1-2)	62,293,170	0	62,293,170	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	750,249	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)	0	0	0	750,249	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	177,832	104,052	64,875	0	1,097,008	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	-7,774	0	0	-7,774	2.00
3.00	Total (sum of lines 1-2)	177,832	96,278	64,875	0	1,089,234	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/9/2021 8:08 am

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 #		
1.00		A	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-123,307	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,355,698			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	2,827,006			0	12.00
13.00	Laundry and linen service	B	-106,467	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-175,001	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	-142	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-9,749	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SPECIAL FUNCTIONS	B	-21,868	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/9/2021 8:08 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #
			1.00	2.00	3.00	4.00
						5.00
34.00	GUEST ROOM	B			0ADULTS & PEDIATRICS	30.00
35.00	MISC REVENUE	B		-3,778	ADMINISTRATIVE & GENERAL	5.00
36.00	MISC REVENUE	B		-567	SPEECH PATHOLOGY	68.00
37.00	MISC REVENUE	B		-600	RURAL HEALTH CLINIC III	88.02
38.00	PHYSICIAN RECRUITMENT	A		-267,843	ADMINISTRATIVE & GENERAL	5.00
39.00	CRNA SALARIES	A		-954,829	ANESTHESIOLOGY	53.00
41.00	CRNA BENEFITS	A		-240,402	EMPLOYEE BENEFITS DEPARTMENT	4.00
42.00	LOBBYING DUES	A		-15,713	ADMINISTRATIVE & GENERAL	5.00
43.00	FOUNDATION SALARIES	A			ADMINISTRATIVE & GENERAL	5.00
44.00	FOUNDATION BENEFITS	A			EMPLOYEE BENEFITS DEPARTMENT	4.00
45.00	FOUNDATION OTHER	A			ADMINISTRATIVE & GENERAL	5.00
46.00	ADVERTISING	A		-26,636	ADMINISTRATIVE & GENERAL	5.00
47.00	PROVIDER TAX ASSESSMENT	A		-2,289,217	ADMINISTRATIVE & GENERAL	5.00
49.02	PROVIDER TAX ASSESSMENT	A		-54,630	SKILLED NURSING FACILITY	44.00
49.03	NON ALLOWABLE EXP	A		-360	ADMINISTRATIVE & GENERAL	5.00
49.04	HOSPITALIST	B			PHYSICIANS' PRIVATE OFFICES	192.00
49.05	MISC REVENUE	B		-100	PHYSICAL THERAPY	66.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-3,819,901		

(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: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/9/2021 8:08 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION	-358,409	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HO ALLOCATION	10,455,721	8,312,460	2.00
3.00	7.00	OPERATION OF PLANT	HO ALLOCATION	628,589	0	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	HO ALLOCATION	127,510	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	HO ALLOCATION	213,895	0	3.02
4.00	88.00	RURAL HEALTH CLINIC	HO ALLOCATION	19,677	0	4.00
4.01	88.01	RURAL HEALTH CLINIC II	HO ALLOCATION	18,005	0	4.01
4.02	88.02	RURAL HEALTH CLINIC III	HO ALLOCATION	23,454	0	4.02
4.03	88.00	RURAL HEALTH CLINIC	CPG BENEFITS	3,293	0	4.03
4.04	88.01	RURAL HEALTH CLINIC II	CPG BENEFITS	5,263	0	4.04
4.05	88.02	RURAL HEALTH CLINIC III	CPG BENEFITS	2,468	0	4.05
4.06	0.00			0	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,139,466	8,312,460	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				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	THE CARLE FOUND	100.00	SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/9/2021 8:08 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-358,409	0		1.00
2.00	2,143,261	0		2.00
3.00	628,589	0		3.00
3.01	127,510	0		3.01
3.02	213,895	0		3.02
4.00	19,677	0		4.00
4.01	18,005	0		4.01
4.02	23,454	0		4.02
4.03	3,293	0		4.03
4.04	5,263	0		4.04
4.05	2,468	0		4.05
4.06	0	0		4.06
5.00	2,827,006			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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/9/2021 8:08 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	20,848	20,848	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	342	342	0	0	0	2.00
3.00	60.00	LABORATORY	103,454	103,454	0	0	0	3.00
4.00	91.00	EMERGENCY	2,231,054	2,231,054	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,355,698	2,355,698	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	20,848		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	342		2.00
3.00	60.00	LABORATORY	0	0	0	103,454		3.00
4.00	91.00	EMERGENCY	0	0	0	2,231,054		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,355,698		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,097,008	1,097,008			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,774		-7,774		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-351,562	3,335	0	-348,227	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,652,665	101,175	0	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,601,634	13,804	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,126,897	48,011	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	423,632	19,799	0	0	8.00
9.00	00900	HOUSEKEEPING	884,143	2,251	0	0	9.00
10.00	01000	DIETARY	377,976	41,535	0	0	10.00
11.00	01100	CAFETERIA	1,073,459	11,783	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,895,136	41,198	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376,692	29,183	0	0	14.00
15.00	01500	PHARMACY	2,519,189	15,782	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	271,835	12,263	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,193,385	159,878	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	880,862	38,401	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	386,448	5,427	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,228,370	19,669	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,327,632	63,994	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85,438	4,882	0	0	52.00
53.00	05300	ANESTHESIOLOGY	322,742	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,171,318	46,263	0	0	54.00
56.00	05600	RADIOISOTOPE	310,904	5,332	0	0	56.00
57.00	05700	CT SCAN	323,648	4,106	0	0	57.00
58.00	05800	MRI	411,917	0	0	0	58.00
60.00	06000	LABORATORY	2,862,027	43,236	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	625,679	4,976	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,094,400	31,594	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	442,621	1,226	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,476	2,133	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	801,420	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,040	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479,690	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,258,976	17,773	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,488,179	18,508	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,308,731	97,751	0	0	88.02
91.00	09100	EMERGENCY	1,518,388	20,214	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,122	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	343,768	7,897	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	233,038	7,897	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,172,149	941,276	0	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,218,552	154,855	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	80	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.01	07952	MEMORY DISORDER	0	877	0	0	877	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	61,197	0	0	0	61,197	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	-7,774	-348,227	-356,001	201.00
202.00		TOTAL (sum lines 118 through 201)	57,451,978	1,097,008	-7,774	-348,227	57,451,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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7/9/2021 8:08 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,753,840					5.00
6.00	00600	MAINTENANCE & REPAIRS	605,158	2,220,596				6.00
7.00	00700	OPERATION OF PLANT	440,131	108,933	1,723,972			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,113	44,923	36,675	691,142		8.00
9.00	00900	HOUSEKEEPING	332,051	5,108	4,170	45,812	1,273,535	9.00
10.00	01000	DIETARY	157,153	94,241	76,939	2,255	0	10.00
11.00	01100	CAFETERIA	406,541	26,736	21,827	8,483	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	725,368	93,475	76,313	0	27,645	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	152,044	66,215	54,058	10,017	17,173	14.00
15.00	01500	PHARMACY	949,623	35,809	29,235	0	7,539	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,426	27,825	22,716	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,256,162	362,754	296,157	179,265	319,379	30.00
31.00	03100	INTENSIVE CARE UNIT	344,364	87,130	71,133	63,654	56,336	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	146,800	12,313	10,052	43,666	35,184	43.00
44.00	04400	SKILLED NURSING FACILITY	467,527	44,627	36,434	192,478	107,227	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	521,316	145,199	118,541	67,529	80,421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,835	11,076	9,043	5,471	9,843	52.00
53.00	05300	ANESTHESIOLOGY	120,902	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,117	104,968	85,696	12,735	55,289	54.00
56.00	05600	RADIOISOTOPE	118,465	12,098	9,877	1,427	13,194	56.00
57.00	05700	CT SCAN	122,780	9,315	7,605	0	13,822	57.00
58.00	05800	MRI	154,308	0	0	0	0	58.00
60.00	06000	LABORATORY	1,088,338	98,099	80,088	2,155	35,184	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	236,249	11,291	9,218	0	5,026	65.00
66.00	06600	PHYSICAL THERAPY	796,416	71,685	58,524	11,106	148,066	66.00
68.00	06800	SPEECH PATHOLOGY	166,269	2,782	2,272	0	17,592	68.00
69.00	06900	ELECTROCARDIOLOGY	9,968	4,839	3,951	0	18,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	300,219	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,349	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	554,305	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	478,282	40,326	32,922	710	48,797	88.00
88.01	08801	RURAL HEALTH CLINIC II	564,419	41,992	34,283	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	901,490	221,791	181,071	0	0	88.02
91.00	09100	EMERGENCY	576,374	45,864	37,443	44,379	123,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	795	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	131,737	17,918	14,628	0	32,671	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	90,256	17,918	14,628	0	32,671	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,717,650	1,867,250	1,435,499	691,142	1,205,052	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,012,906	351,357	286,849	0	68,483	192.00
194.00	07950	OTHER NONREIMBURSABLE	30	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	329	1,989	1,624	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	22,925	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 7/9/2021 8:08 am	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
202.00		TOTAL (sum lines 118 through 201)	5.00 15,753,840	6.00 2,220,596	7.00 1,723,972	8.00 691,142	9.00 1,273,535
							202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	750,099					10.00
11.00	01100	CAFETERIA	0	1,548,829				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	97,452	0	2,956,587		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,616	0	0	726,998	14.00
15.00	01500	PHARMACY	0	68,442	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,305	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	242,160	63,559	0	971,849	0	30.00
31.00	03100	INTENSIVE CARE UNIT	38,645	7,768	0	212,855	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	101,278	0	43.00
44.00	04400	SKILLED NURSING FACILITY	461,917	34,272	0	444,908	5,128	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	64,625	0	153,957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,377	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	38,544	0	0	15,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,093	0	0	4,214	54.00
56.00	05600	RADIOISOTOPE	0	8,369	0	0	1,660	56.00
57.00	05700	CT SCAN	0	15,834	0	0	17,164	57.00
58.00	05800	MRI	0	11,065	0	0	2,910	58.00
60.00	06000	LABORATORY	0	65,221	0	0	278,717	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,024	0	0	6,443	65.00
66.00	06600	PHYSICAL THERAPY	0	216,396	0	0	5,899	66.00
68.00	06800	SPEECH PATHOLOGY	0	22,910	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	265	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	283,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	37,196	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	117,590	0	181,779	3,380	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	82,690	0	164,495	617	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	192,290	0	381,931	4,228	88.02
91.00	09100	EMERGENCY	0	8,153	0	343,535	32,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	37,618	0	0	3,585	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	16,094	0	0	677	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	750,099	1,244,930	0	2,956,587	703,932	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	303,899	0	0	23,066	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	750,099	1,548,829	0	2,956,587	726,998	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,625,619					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	442,370				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	92,450	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,959	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	6,959	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,947	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	138,178	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,982	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,935	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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	21,870	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	3,562,289	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,865	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,210	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	14,088	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	46,722	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,594,452	336,002	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,167	106,368	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,625,619	442,370	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	7,136,998	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,808,107	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	748,127	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,051,504	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,681,392	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	169,947	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	497,663	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,984,628	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	481,326	0	56.00
57.00	05700	CT SCAN	0	0	0	514,274	0	57.00
58.00	05800	MRI	0	0	0	580,200	0	58.00
60.00	06000	LABORATORY	0	0	0	4,574,935	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	914,906	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,434,086	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	655,672	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	64,481	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,385,434	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	181,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,596,284	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,188,400	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,405,393	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	4,303,371	0	88.02
91.00	09100	EMERGENCY	0	0	0	2,796,795	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	2,917	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	589,822	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE			0	413,179	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	49,161,426	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	8,557,502	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	110	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
194.01	07952	MEMORY DISORDER	0	0	0	4,819	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	84,122	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-356,001	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	57,451,978	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
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	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
194.03	07951	CONTRACTED RETAIL RX	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	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	3,335	0	3,335	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,057	101,175	0	105,232	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,804	0	13,804	6.00
7.00	00700	OPERATION OF PLANT	0	48,011	0	48,011	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,799	0	19,799	8.00
9.00	00900	HOUSEKEEPING	0	2,251	0	2,251	9.00
10.00	01000	DIETARY	0	41,535	0	41,535	10.00
11.00	01100	CAFETERIA	0	11,783	0	11,783	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	41,198	0	41,198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,183	0	29,183	14.00
15.00	01500	PHARMACY	5,402	15,782	0	21,184	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,263	0	12,263	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,708	159,878	0	174,586	30.00
31.00	03100	INTENSIVE CARE UNIT	2,175	38,401	0	40,576	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	5,427	0	5,427	43.00
44.00	04400	SKILLED NURSING FACILITY	-180	19,669	0	19,489	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	63,994	0	63,994	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,882	0	4,882	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,263	0	46,263	54.00
56.00	05600	RADIOISOTOPE	0	5,332	0	5,332	56.00
57.00	05700	CT SCAN	0	4,106	0	4,106	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	43,236	0	43,236	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,372	4,976	0	14,348	65.00
66.00	06600	PHYSICAL THERAPY	0	31,594	0	31,594	66.00
68.00	06800	SPEECH PATHOLOGY	0	1,226	0	1,226	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,133	0	2,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	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	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	17,773	0	17,773	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	18,508	0	18,508	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	97,751	0	97,751	88.02
91.00	09100	EMERGENCY	0	20,214	0	20,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	9,150	7,897	0	17,047	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	7,897	0	7,897	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,684	941,276	0	985,960	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	154,855	0	154,855	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	877	0	877	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
194.02	07953	ASSISTED LIVING	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	559	0	0	559	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	-7,774	-7,774	201.00
202.00		TOTAL (sum lines 118 through 201)	45,243	1,097,008	-7,774	1,134,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	105,232					5.00
6.00	00600	MAINTENANCE & REPAIRS	4,042	17,846				6.00
7.00	00700	OPERATION OF PLANT	2,940	875	51,826			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,109	361	1,103	22,372		8.00
9.00	00900	HOUSEKEEPING	2,218	41	125	1,483	6,118	9.00
10.00	01000	DIETARY	1,050	757	2,313	73	0	10.00
11.00	01100	CAFETERIA	2,715	215	656	275	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,845	751	2,294	0	133	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,015	532	1,625	324	82	14.00
15.00	01500	PHARMACY	6,342	288	879	0	36	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	711	224	683	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,390	2,916	8,902	5,803	1,535	30.00
31.00	03100	INTENSIVE CARE UNIT	2,300	700	2,138	2,060	271	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	980	99	302	1,413	169	43.00
44.00	04400	SKILLED NURSING FACILITY	3,123	359	1,095	6,231	515	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,482	1,167	3,564	2,186	386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	226	89	272	177	47	52.00
53.00	05300	ANESTHESIOLOGY	808	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,046	844	2,576	412	266	54.00
56.00	05600	RADIOISOTOPE	791	97	297	46	63	56.00
57.00	05700	CT SCAN	820	75	229	0	66	57.00
58.00	05800	MRI	1,031	0	0	0	0	58.00
60.00	06000	LABORATORY	7,269	788	2,408	70	169	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,578	91	277	0	24	65.00
66.00	06600	PHYSICAL THERAPY	5,319	576	1,759	359	711	66.00
68.00	06800	SPEECH PATHOLOGY	1,111	22	68	0	85	68.00
69.00	06900	ELECTROCARDIOLOGY	67	39	119	0	91	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,005	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	263	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,702	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,194	324	990	23	234	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,770	337	1,031	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,021	1,782	5,443	0	0	88.02
91.00	09100	EMERGENCY	3,850	369	1,126	1,437	592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	880	144	440	0	157	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	603	144	440	0	157	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,621	15,006	43,154	22,372	5,789	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,456	2,824	8,623	0	329	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	2	16	49	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	153	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
202.00	TOTAL (sum lines 118 through 201)	105,232	17,846	51,826	22,372	6,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	45,728					10.00
11.00	01100	CAFETERIA	0	15,644				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	984	0	50,205		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	218	0	0	32,979	14.00
15.00	01500	PHARMACY	0	691	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,763	642	0	16,504	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,356	78	0	3,614	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	1,720	0	43.00
44.00	04400	SKILLED NURSING FACILITY	28,159	346	0	7,555	233	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	653	0	2,614	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	450	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	389	0	0	702	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	375	0	0	191	54.00
56.00	05600	RADIOISOTOPE	0	85	0	0	75	56.00
57.00	05700	CT SCAN	0	160	0	0	779	57.00
58.00	05800	MRI	0	112	0	0	132	58.00
60.00	06000	LABORATORY	0	659	0	0	12,644	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	162	0	0	292	65.00
66.00	06600	PHYSICAL THERAPY	0	2,186	0	0	268	66.00
68.00	06800	SPEECH PATHOLOGY	0	231	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	12	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	12,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,687	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,188	0	3,087	153	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	835	0	2,793	28	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,942	0	6,485	192	88.02
91.00	09100	EMERGENCY	0	82	0	5,833	1,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	380	0	0	163	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	163	0	0	31	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,728	12,574	0	50,205	31,933	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,070	0	0	1,046	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	45,728	15,644	0	50,205	32,979	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	29,420					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,894				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,904	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	219	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0			40.00
43.00	04300	NURSERY	0	219	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	281	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,339	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	94	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	343	0			54.00
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
60.00	06000	LABORATORY	0	687	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,906	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPS	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	64	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	83	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	114	0	0			88.02
91.00	09100	EMERGENCY	0	1,467	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0			95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,167	10,553	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	253	3,341	0			192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0			194.00
194.01	07952	MEMORY DISORDER	0	0	0			194.01
194.02	07953	ASSISTED LIVING	0	0	0			194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0			194.03
200.00		Cross Foot Adjustments				0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	29,420	13,894	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				236,945	0	30.00
31.00	03100	INTENSIVE CARE UNIT				54,312	0	31.00
40.00	04000	SUBPROVIDER - IPF				0	0	40.00
43.00	04300	NURSERY				10,329	0	43.00
44.00	04400	SKILLED NURSING FACILITY				67,386	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				82,385	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				6,237	0	52.00
53.00	05300	ANESTHESIOLOGY				1,899	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				54,316	0	54.00
56.00	05600	RADIOISOTOPE				6,786	0	56.00
57.00	05700	CT SCAN				6,235	0	57.00
58.00	05800	MRI				1,275	0	58.00
60.00	06000	LABORATORY				67,930	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				0	0	64.00
65.00	06500	RESPIRATORY THERAPY				16,772	0	65.00
66.00	06600	PHYSICAL THERAPY				42,772	0	66.00
68.00	06800	SPEECH PATHOLOGY				2,743	0	68.00
69.00	06900	ELECTROCARDIOLOGY				2,461	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				14,878	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				1,950	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				32,608	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				27,030	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				27,385	0	88.01
88.02	08802	RURAL HEALTH CLINIC III				119,730	0	88.02
91.00	09100	EMERGENCY				36,448	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES				5	0	95.00
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				19,211	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE				9,435	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	949,463	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				187,797	0	192.00
194.00	07950	OTHER NONREIMBURSABLE				0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
194.01	07952	MEMORY DISORDER				944	0	194.01
194.02	07953	ASSISTED LIVING				0	0	194.02
194.03	07951	CONTRACTED RETAIL RX				712	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-4,439	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,134,477	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
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	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
194.03	07951	CONTRACTED RETAIL RX	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,171					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,719,981				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	563	0	22,801,008			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,078	324,315	2,430,101	-15,753,840	42,054,139	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,330	168,458	838,372	0	1,615,438	6.00
7.00	00700	OPERATION OF PLANT	8,104	0	0	0	1,174,908	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	12,205	278,612	0	443,431	8.00
9.00	00900	HOUSEKEEPING	380	3,647	537,477	0	886,394	9.00
10.00	01000	DIETARY	7,011	16,415	149,793	0	419,511	10.00
11.00	01100	CAFETERIA	1,989	0	507,298	0	1,085,242	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,954	190,717	1,273,254	0	1,936,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	29,180	85,082	0	405,875	14.00
15.00	01500	PHARMACY	2,664	54,492	863,293	0	2,534,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	3,301	4,007	0	284,098	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,987	39,445	2,430,005	0	3,353,263	30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	12,134	646,425	0	919,263	31.00
40.00	04000	SUBPROVIDER - IPF	0	190	0	0	0	40.00
43.00	04300	NURSERY	916	3,815	285,881	0	391,875	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	10,709	942,454	0	1,248,039	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,802	141,232	641,349	0	1,391,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	824	1,103	65,761	0	90,320	52.00
53.00	05300	ANESTHESIOLOGY	0	49,374	954,829	0	322,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	191,771	712,272	0	1,217,581	54.00
56.00	05600	RADIOISOTOPE	900	22,400	98,077	0	316,236	56.00
57.00	05700	CT SCAN	693	19,610	116,165	0	327,754	57.00
58.00	05800	MRI	0	242,304	56,801	0	411,917	58.00
60.00	06000	LABORATORY	7,298	72,438	1,042,447	0	2,905,263	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840	10,794	433,795	0	630,655	65.00
66.00	06600	PHYSICAL THERAPY	5,333	20,324	1,578,862	0	2,125,994	66.00
68.00	06800	SPEECH PATHOLOGY	207	2,356	184,359	0	443,847	68.00
69.00	06900	ELECTROCARDIOLOGY	360	9,339	0	0	26,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	801,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	105,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,479,690	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,000	14,345	505,187	0	1,276,749	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	0	549,969	0	1,506,687	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,500	0	1,359,669	0	2,406,482	88.02
91.00	09100	EMERGENCY	3,412	28,080	998,855	0	1,538,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,122	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,333	70	210,954	0	351,665	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,333	793	90,005	0	240,935	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,884	1,695,356	20,871,410	-15,753,840	36,618,578	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	24,625	1,929,598	0	5,373,407	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	80	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)				
			1.00	2.00	4.00	5A	5.00	
194.01	07952	MEMORY DISORDER	148	0	0	0	877	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	61,197	194.03
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)	1,097,008	-7,774	-348,227		15,753,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.924297	0.000000	0.000000		0.374609	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,335		105,232	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000146		0.002502	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	165,200				6.00
7.00	00700	OPERATION OF PLANT	8,104	157,096			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	3,342	461,198		8.00
9.00	00900	HOUSEKEEPING	380	380	30,570	6,081	9.00
10.00	01000	DIETARY	7,011	7,011	1,505	0	11,083 10.00
11.00	01100	CAFETERIA	1,989	1,989	5,661	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	6,954	6,954	0	132	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	4,926	6,684	82	0 14.00
15.00	01500	PHARMACY	2,664	2,664	0	36	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	2,070	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,987	26,987	119,623	1,525	3,578 30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	6,482	42,476	269	571 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
43.00	04300	NURSERY	916	916	29,138	168	0 43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	3,320	128,441	512	6,825 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,802	10,802	45,062	384	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	824	824	3,651	47	109 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	7,809	8,498	264	0 54.00
56.00	05600	RADIOISOTOPE	900	900	952	63	0 56.00
57.00	05700	CT SCAN	693	693	0	66	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	7,298	7,298	1,438	168	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	840	840	0	24	0 65.00
66.00	06600	PHYSICAL THERAPY	5,333	5,333	7,411	707	0 66.00
68.00	06800	SPEECH PATHOLOGY	207	207	0	84	0 68.00
69.00	06900	ELECTROCARDIOLOGY	360	360	0	90	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,000	3,000	474	233	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	3,124	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	16,500	16,500	0	0	0 88.02
91.00	09100	EMERGENCY	3,412	3,412	29,614	588	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
101.00	10100	HOME HEALTH AGENCY	1,333	1,333	0	156	0 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,333	1,333	0	156	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,913	130,809	461,198	5,754	11,083 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	26,139	0	327	0 192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0 194.00
194.01	07952	MEMORY DISORDER	148	148	0	0	0 194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0 194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0 194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
		6.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,220,596	1,723,972	691,142	1,273,535	750,099	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.441864	10.974003	1.498580	209.428548	67.680141	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,846	51,826	22,372	6,118	45,728	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.108027	0.329900	0.048508	1.006085	4.125959	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	286,109					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	18,002	0	247,175			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,993	0	0	2,053,004		14.00
15.00	01500	PHARMACY	12,643	0	0	0	1,505,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,741	0	81,248	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,435	0	17,795	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	8,467	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,331	0	37,195	14,482	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,938	0	12,871	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,120	0	0	43,700	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,852	0	0	11,899	0	54.00
56.00	05600	RADIOISOTOPE	1,546	0	0	4,688	0	56.00
57.00	05700	CT SCAN	2,925	0	0	48,470	0	57.00
58.00	05800	MRI	2,044	0	0	8,219	0	58.00
60.00	06000	LABORATORY	12,048	0	0	787,082	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,960	0	0	18,194	0	65.00
66.00	06600	PHYSICAL THERAPY	39,974	0	0	16,658	0	66.00
68.00	06800	SPEECH PATHOLOGY	4,232	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	748	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	801,421	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	105,040	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,479,690	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	21,722	0	15,197	9,546	3,267	88.00
88.01	08801	RURAL HEALTH CLINIC II	15,275	0	13,752	1,741	4,241	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,521	0	31,930	11,941	5,852	88.02
91.00	09100	EMERGENCY	1,506	0	28,720	92,002	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	6,949	0	0	10,124	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	2,973	0	0	1,911	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	229,971	0	247,175	1,987,866	1,493,050	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,138	0	0	65,138	12,946	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
			11.00	12.00	13.00	14.00	15.00	
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
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)	1,548,829	0	2,956,587	726,998	3,625,619	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.413423	0.000000	11.961513	0.354114	2.407456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,644	0	50,205	32,979	29,420	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054678	0.000000	0.203115	0.016064	0.019535	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	445					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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	22	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	47	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0		0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	0	0	0	194.03
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)	442,370	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	994.089888	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,894	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.222472	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.01	07952	MEMORY DISORDER	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	194.02
194.03	07951	CONTRACTED RETAIL RX	0	0	194.03
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

			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	7,136,998		7,136,998	0	7,136,998	30.00
31.00	03100	INTENSIVE CARE UNIT	1,808,107		1,808,107	0	1,808,107	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	748,127		748,127	0	748,127	43.00
44.00	04400	SKILLED NURSING FACILITY	3,051,504		3,051,504	0	3,051,504	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,681,392		2,681,392	0	2,681,392	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,947		169,947	0	169,947	52.00
53.00	05300	ANESTHESIOLOGY	497,663		497,663	0	497,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,984,628		1,984,628	0	1,984,628	54.00
56.00	05600	RADIOISOTOPE	481,326		481,326	0	481,326	56.00
57.00	05700	CT SCAN	514,274		514,274	0	514,274	57.00
58.00	05800	MRI	580,200		580,200	0	580,200	58.00
60.00	06000	LABORATORY	4,574,935		4,574,935	0	4,574,935	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	914,906	0	914,906	0	914,906	65.00
66.00	06600	PHYSICAL THERAPY	3,434,086	0	3,434,086	0	3,434,086	66.00
68.00	06800	SPEECH PATHOLOGY	655,672	0	655,672	0	655,672	68.00
69.00	06900	ELECTROCARDIOLOGY	64,481		64,481	0	64,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,385,434		1,385,434	0	1,385,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,585		181,585	0	181,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,596,284		5,596,284	0	5,596,284	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,188,400		2,188,400	0	2,188,400	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,405,393		2,405,393	0	2,405,393	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,303,371		4,303,371	0	4,303,371	88.02
91.00	09100	EMERGENCY	2,796,795		2,796,795	0	2,796,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,608,767		1,608,767	0	1,608,767	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,917		2,917	0	2,917	95.00
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	589,822		589,822	0	589,822	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	413,179		413,179	0	413,179	116.00
200.00		Subtotal (see instructions)	50,770,193	0	50,770,193	0	50,770,193	200.00
201.00		Less Observation Beds	1,608,767		1,608,767	0	1,608,767	201.00
202.00		Total (see instructions)	49,161,426	0	49,161,426	0	49,161,426	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

			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	5,023,689		5,023,689			30.00
31.00	03100	INTENSIVE CARE UNIT	2,723,021		2,723,021			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	374,147		374,147			43.00
44.00	04400	SKILLED NURSING FACILITY	1,238,178		1,238,178			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,674,112	8,932,502	10,606,614	0.252804	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	234,843	0	234,843	0.723662	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	816,084	3,868,979	4,685,063	0.106223	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,112,567	11,413,121	12,525,688	0.158445	0.000000	54.00
56.00	05600	RADIOISOTOPE	79,134	2,805,783	2,884,917	0.166842	0.000000	56.00
57.00	05700	CT SCAN	2,047,781	20,709,157	22,756,938	0.022599	0.000000	57.00
58.00	05800	MRI	199,974	4,814,643	5,014,617	0.115702	0.000000	58.00
60.00	06000	LABORATORY	5,000,542	23,317,169	28,317,711	0.161557	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,811,930	652,872	3,464,802	0.264057	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,223,677	10,632,262	12,855,939	0.267121	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	192,264	990,567	1,182,831	0.554324	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	273,054	2,382,922	2,655,976	0.024278	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	795,412	5,633,464	6,428,876	0.215502	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	400,000	104,752	504,752	0.359751	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,394,723	6,637,151	11,031,874	0.507283	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,120,987	2,120,987			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,940,807	1,940,807			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,528,104	2,528,104			88.02
91.00	09100	EMERGENCY	2,210,303	16,909,484	19,119,787	0.146278	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	627,306	2,026,704	2,654,010	0.606165	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	155,272	155,272	0.018786	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	364,592	364,592			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	3,044	691,041	694,085			116.00
200.00		Subtotal (see instructions)	34,455,785	129,632,335	164,088,120			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,455,785	129,632,335	164,088,120			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.252804		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.723662		52.00
53.00	05300	ANESTHESIOLOGY	0.106223		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158445		54.00
56.00	05600	RADIOISOTOPE	0.166842		56.00
57.00	05700	CT SCAN	0.022599		57.00
58.00	05800	MRI	0.115702		58.00
60.00	06000	LABORATORY	0.161557		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.264057		65.00
66.00	06600	PHYSICAL THERAPY	0.267121		66.00
68.00	06800	SPEECH PATHOLOGY	0.554324		68.00
69.00	06900	ELECTROCARDIOLOGY	0.024278		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.215502		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359751		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507283		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.146278		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606165		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.018786		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

			Title XIX			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	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,681,392	82,385	2,599,007	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,947	6,237	163,710	0	0
53.00	05300	ANESTHESIOLOGY	497,663	1,899	495,764	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,984,628	54,316	1,930,312	0	0
56.00	05600	RADIOISOTOPE	481,326	6,786	474,540	0	0
57.00	05700	CT SCAN	514,274	6,235	508,039	0	0
58.00	05800	MRI	580,200	1,275	578,925	0	0
60.00	06000	LABORATORY	4,574,935	67,930	4,507,005	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	914,906	16,772	898,134	0	0
66.00	06600	PHYSICAL THERAPY	3,434,086	42,772	3,391,314	0	0
68.00	06800	SPEECH PATHOLOGY	655,672	2,743	652,929	0	0
69.00	06900	ELECTROCARDIOLOGY	64,481	2,461	62,020	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,385,434	14,878	1,370,556	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,585	1,950	179,635	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,596,284	32,608	5,563,676	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,188,400	27,030	2,161,370	0	0
88.01	08801	RURAL HEALTH CLINIC II	2,405,393	27,385	2,378,008	0	0
88.02	08802	RURAL HEALTH CLINIC III	4,303,371	119,730	4,183,641	0	0
91.00	09100	EMERGENCY	2,796,795	36,448	2,760,347	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,608,767	53,411	1,555,356	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,917	5	2,912	0	0
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	589,822	19,211	570,611	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	413,179	9,435	403,744	0	0
200.00		Subtotal (sum of lines 50 thru 199)	38,025,457	633,902	37,391,555	0	0
201.00		Less Observation Beds	1,608,767	53,411	1,555,356	0	0
202.00		Total (line 200 minus line 201)	36,416,690	580,491	35,836,199	0	0

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

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,681,392	10,606,614	0.252804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,947	234,843	0.723662	52.00
53.00	05300	ANESTHESIOLOGY	497,663	4,685,063	0.106223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,984,628	12,525,688	0.158445	54.00
56.00	05600	RADIOISOTOPE	481,326	2,884,917	0.166842	56.00
57.00	05700	CT SCAN	514,274	22,756,938	0.022599	57.00
58.00	05800	MRI	580,200	5,014,617	0.115702	58.00
60.00	06000	LABORATORY	4,574,935	28,317,711	0.161557	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	914,906	3,464,802	0.264057	65.00
66.00	06600	PHYSICAL THERAPY	3,434,086	12,855,939	0.267121	66.00
68.00	06800	SPEECH PATHOLOGY	655,672	1,182,831	0.554324	68.00
69.00	06900	ELECTROCARDIOLOGY	64,481	2,655,976	0.024278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,385,434	6,428,876	0.215502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,585	504,752	0.359751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,596,284	11,031,874	0.507283	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,188,400	2,120,987	1.031784	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,405,393	1,940,807	1.239378	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,303,371	2,528,104	1.702213	88.02
91.00	09100	EMERGENCY	2,796,795	19,119,787	0.146278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,608,767	2,654,010	0.606165	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,917	155,272	0.018786	95.00
99.10	09910	CORF	0	0	0.000000	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
101.00	10100	HOME HEALTH AGENCY	589,822	364,592	1.617759	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	413,179	694,085	0.595286	116.00
200.00		Subtotal (sum of lines 50 thru 199)	38,025,457	154,729,085		200.00
201.00		Less Observation Beds	1,608,767	0		201.00
202.00		Total (line 200 minus line 201)	36,416,690	154,729,085		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/9/2021 8:08 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	236,945	11,710	225,235	4,099	54.95	30.00	
31.00	INTENSIVE CARE UNIT	54,312		54,312	583	93.16	31.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
43.00	NURSERY	10,329		10,329	244	42.33	43.00	
44.00	SKILLED NURSING FACILITY	67,386		67,386	4,773	14.12	44.00	
200.00	Total (lines 30 through 199)	368,972		357,262	9,699		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	1,628	89,459					30.00
31.00	INTENSIVE CARE UNIT	356	33,165					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	1,984	122,624					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/9/2021 8:08 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,385	10,606,614	0.007767	884,753	6,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,237	234,843	0.026558	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,899	4,685,063	0.000405	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,316	12,525,688	0.004336	791,136	3,430	54.00
56.00	05600	RADIOISOTOPE	6,786	2,884,917	0.002352	21,670	51	56.00
57.00	05700	CT SCAN	6,235	22,756,938	0.000274	1,478,233	405	57.00
58.00	05800	MRI	1,275	5,014,617	0.000254	16,820	4	58.00
60.00	06000	LABORATORY	67,930	28,317,711	0.002399	2,922,677	7,012	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,772	3,464,802	0.004841	1,427,355	6,910	65.00
66.00	06600	PHYSICAL THERAPY	42,772	12,855,939	0.003327	433,767	1,443	66.00
68.00	06800	SPEECH PATHOLOGY	2,743	1,182,831	0.002319	77,671	180	68.00
69.00	06900	ELECTROCARDIOLOGY	2,461	2,655,976	0.000927	220,888	205	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,878	6,428,876	0.002314	493,620	1,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	504,752	0.003863	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,608	11,031,874	0.002956	2,477,033	7,322	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	27,030	2,120,987	0.012744	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	27,385	1,940,807	0.014110	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	119,730	2,528,104	0.047360	0	0	88.02
91.00	09100	EMERGENCY	36,448	19,119,787	0.001906	1,306,428	2,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,411	2,654,010	0.020125	440,842	8,872	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	605,251	153,515,136		12,992,893	46,338	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/9/2021 8:08 am		
					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	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		0	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	4,099	0.00	1,628		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	583	0.00	356		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0		40.00		
43.00	04300	NURSERY	0	0	244	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	4,773	0.00	0		44.00		
200.00	Total (lines 30 through 199)		0	0	9,699	0.00	1,984		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
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/9/2021 8:08 am

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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	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	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/9/2021 8:08 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,606,614	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	234,843	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,685,063	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,525,688	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,884,917	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	22,756,938	0.000000	57.00
58.00	05800	MRI	0	0	0	5,014,617	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	28,317,711	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,464,802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,855,939	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,182,831	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,655,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,428,876	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	504,752	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,031,874	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,120,987	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,940,807	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,528,104	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	19,119,787	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,654,010	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	153,515,136		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
Cost Center Description				Title XVIII		Hospital		PPS	
				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		884,753	0	2,979,003	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		791,136	0	4,129,027	0	54.00
56.00	05600	RADIOISOTOPE	0.000000		21,670	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		1,478,233	0	6,005,159	0	57.00
58.00	05800	MRI	0.000000		16,820	0	1,232,408	0	58.00
60.00	06000	LABORATORY	0.000000		2,922,677	0	3,304,787	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		1,427,355	0	300,781	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		433,767	0	44,466	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		77,671	0	61,925	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		220,888	0	822,199	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		493,620	0	938,392	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	63,302	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		2,477,033	0	2,996,719	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000		1,306,428	0	2,921,092	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		440,842	0	1,257,253	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			12,992,893	0	27,056,513	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/9/2021 8:08 am

			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	0.252804	2,979,003	0	0	753,104	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.723662	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106223	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158445	4,129,027	0	0	654,224	54.00
56.00	05600	RADIOISOTOPE	0.166842	0	0	0	0	56.00
57.00	05700	CT SCAN	0.022599	6,005,159	0	0	135,711	57.00
58.00	05800	MRI	0.115702	1,232,408	0	0	142,592	58.00
60.00	06000	LABORATORY	0.161557	3,304,787	0	0	533,911	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.264057	300,781	0	0	79,423	65.00
66.00	06600	PHYSICAL THERAPY	0.267121	44,466	0	0	11,878	66.00
68.00	06800	SPEECH PATHOLOGY	0.554324	61,925	0	0	34,327	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024278	822,199	0	0	19,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.215502	938,392	0	0	202,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359751	63,302	0	3,117	22,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507283	2,996,719	0	0	1,520,185	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.146278	2,921,092	0	0	427,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606165	1,257,253	0	0	762,103	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.018786		0			95.00
200.00		Subtotal (see instructions)		27,056,513	0	3,117	5,299,708	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		27,056,513	0	3,117	5,299,708	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/9/2021 8:08 am

			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
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
56.00	05600	RADIOISOTOPE	0	0		56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,121		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,121		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,121		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:

Worksheet D

Component CCN: 14-S147

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/9/2021 8:08 am

Title XVIII

Subprovider -

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	82,385	10,606,614	0.007767	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,237	234,843	0.026558	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,899	4,685,063	0.000405	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	54,316	12,525,688	0.004336	0	0	54.00
56.00	05600 RADIOISOTOPE	6,786	2,884,917	0.002352	0	0	56.00
57.00	05700 CT SCAN	6,235	22,756,938	0.000274	0	0	57.00
58.00	05800 MRI	1,275	5,014,617	0.000254	0	0	58.00
60.00	06000 LABORATORY	67,930	28,317,711	0.002399	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	16,772	3,464,802	0.004841	0	0	65.00
66.00	06600 PHYSICAL THERAPY	42,772	12,855,939	0.003327	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	2,743	1,182,831	0.002319	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,461	2,655,976	0.000927	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,878	6,428,876	0.002314	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,950	504,752	0.003863	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32,608	11,031,874	0.002956	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	27,030	2,120,987	0.012744	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	27,385	1,940,807	0.014110	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	119,730	2,528,104	0.047360	0	0	88.02
91.00	09100 EMERGENCY	36,448	19,119,787	0.001906	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,654,010	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	551,840	153,515,136		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		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
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,606,614	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	234,843	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,685,063	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,525,688	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,884,917	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	22,756,938	0.000000	57.00
58.00	05800	MRI	0	0	0	5,014,617	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	28,317,711	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,464,802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,855,939	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,182,831	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,655,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,428,876	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	504,752	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,031,874	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,120,987	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,940,807	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,528,104	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	19,119,787	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,654,010	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	153,515,136		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
				Title XVIII		Subprovider - IPF		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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/9/2021 8:08 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	236,945	11,710	225,235	4,099	54.95	30.00
31.00	INTENSIVE CARE UNIT	54,312		54,312	583	93.16	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	10,329		10,329	244	42.33	43.00
44.00	SKILLED NURSING FACILITY	67,386		67,386	4,773	14.12	44.00
200.00	Total (lines 30 through 199)	368,972		357,262	9,699		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	85	4,671				30.00
31.00	INTENSIVE CARE UNIT	21	1,956				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	80	3,386				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	186	10,013				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	82,385	0	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,237	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1,899	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,316	0	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	6,786	0	0.000000	0	56.00
57.00	05700	CT SCAN	6,235	0	0.000000	0	57.00
58.00	05800	MRI	1,275	0	0.000000	0	58.00
60.00	06000	LABORATORY	67,930	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,772	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	42,772	0	0.000000	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,743	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,461	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,878	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,608	0	0.000000	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	27,030	0	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	27,385	0	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	119,730	0	0.000000	0	88.02
91.00	09100	EMERGENCY	36,448	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,411	0	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	605,251	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/9/2021 8:08 am		
					Title XIX		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	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	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	4,099	0.00	85	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	583	0.00	21	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00			
43.00	04300	NURSERY	0	0	244	0.00	80	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	4,773	0.00	0	44.00			
200.00		Total (lines 30 through 199)	0	0	9,699		186	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
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Title XIX		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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	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	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/9/2021 8:08 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Title XIX		Hospital		PPS	
		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	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/9/2021 8:08 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		82,385	0	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		6,237	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY		1,899	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		54,316	0	0.000000	0	0	54.00
56.00	05600	RADIOISOTOPE		6,786	0	0.000000	0	0	56.00
57.00	05700	CT SCAN		6,235	0	0.000000	0	0	57.00
58.00	05800	MRI		1,275	0	0.000000	0	0	58.00
60.00	06000	LABORATORY		67,930	0	0.000000	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		16,772	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY		42,772	0	0.000000	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		2,743	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		2,461	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		14,878	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		1,950	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		32,608	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		27,030	0	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		27,385	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		119,730	0	0.000000	0	0	88.02
91.00	09100	EMERGENCY		36,448	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		551,840	0		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		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
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/9/2021 8:08 am	
				Title XIX		Subprovider - IPF		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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
		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)		5,581	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,099	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)		3,127	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,482	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,628	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)		1,482	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		237.99	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		243.34	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		224.47	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		224.47	20.00	
21.00	Total general inpatient routine service cost (see instructions)		7,136,998	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)		352,701	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)		352,701	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,784,297	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,784,297	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)		1,655.11	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,694,519	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,694,519	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Title XVIII		Hospital		PPS
		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	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,808,107	583	3,101.38	356	1,104,091
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,222,615
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,021,225
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					122,624
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					46,338
52.00	Total Program excludable cost (sum of lines 50 and 51)					168,962
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,852,263
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)					352,701
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)					352,701
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)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					972
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,655.11
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,608,767

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/9/2021 8:08 am

		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	236,945	7,136,998	0.033200	1,608,767	53,411	90.00
91.00 Nursing School cost	0	7,136,998	0.000000	1,608,767	0	91.00
92.00 Allied health cost	0	7,136,998	0.000000	1,608,767	0	92.00
93.00 All other Medical Education	0	7,136,998	0.000000	1,608,767	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am
		Title XVIII	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		0	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)		0	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)	0		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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII		Subprovider - IPF		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	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
			Title XVIII		Subprovider - IPF	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2020	Worksheet D-1	
		Component CCN: 14-5580	To 12/31/2020	Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	Skilled Nursing Facility	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)		4,773	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,773	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)		4,773	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		3,051,504	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)		3,051,504	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)		3,051,504	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)			38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-5580		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII		Skilled Nursing Facility		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)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges							54.00
55.00 Target amount per discharge							55.00
56.00 Target amount (line 54 x line 55)							56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00 Bonus payment (see instructions)							58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00 Relief payment (see instructions)							62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,051,504		70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					639.33		71.00
72.00 Program routine service cost (line 9 x line 71)					0		72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0		73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0		74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0		75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00		76.00
77.00 Program capital-related costs (line 9 x line 76)					0		77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0		78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0		79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0		80.00
81.00 Inpatient routine service cost per diem limitation					0.00		81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0		82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0		83.00
84.00 Program inpatient ancillary services (see instructions)					0		84.00
85.00 Utilization review - physician compensation (see instructions)					0		85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0		86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:

Worksheet D-1

Component CCN: 14-5580

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

Title XVIII

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,581	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,099	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)		3,127	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,482	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		85	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		244	15.00
16.00	Nursery days (title V or XIX only)		80	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		237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		224.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		224.47	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,136,998	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)		352,701	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)		352,701	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,784,297	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,784,297	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)		1,655.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		140,684	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)		140,684	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/9/2021 8:08 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	748,127	244	3,066.09	80	245,287	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	1,808,107	583	3,101.38	21	65,129	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						451,100	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						10,013	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						10,013	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						441,087	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						972	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,655.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,608,767	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/9/2021 8:08 am

		Title XIX		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	236,945	7,136,998	0.033200	1,608,767	53,411	90.00
91.00 Nursing School cost	0	7,136,998	0.000000	1,608,767	0	91.00
92.00 Allied health cost	0	7,136,998	0.000000	1,608,767	0	92.00
93.00 All other Medical Education	0	7,136,998	0.000000	1,608,767	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am
		Title XIX	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		244	15.00
16.00	Nursery days (title V or XIX only)		80	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)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
		Title XIX		Subprovider - IPF		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	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 8:08 am	
			Title XIX		Subprovider - IPF	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/9/2021 8:08 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		2,181,670		30.00
31.00	03100	INTENSIVE CARE UNIT		2,006,146		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.252804	884,753	223,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.723662	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106223	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158445	791,136	125,352	54.00
56.00	05600	RADIOISOTOPE	0.166842	21,670	3,615	56.00
57.00	05700	CT SCAN	0.022599	1,478,233	33,407	57.00
58.00	05800	MRI	0.115702	16,820	1,946	58.00
60.00	06000	LABORATORY	0.161557	2,922,677	472,179	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.264057	1,427,355	376,903	65.00
66.00	06600	PHYSICAL THERAPY	0.267121	433,767	115,868	66.00
68.00	06800	SPEECH PATHOLOGY	0.554324	77,671	43,055	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024278	220,888	5,363	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.215502	493,620	106,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359751	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507283	2,477,033	1,256,557	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.146278	1,306,428	191,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606165	440,842	267,223	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,992,893	3,222,615	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)		12,992,893		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3
			Component CCN: 14-U147		Date/Time Prepared: 7/9/2021 8:08 am
			Title XVIII	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		738,710	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.252804	1,286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.723662	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106223	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158445	290,801	54.00
56.00	05600	RADIOISOTOPE	0.166842	0	56.00
57.00	05700	CT SCAN	0.022599	22,840	57.00
58.00	05800	MRI	0.115702	5,077	58.00
60.00	06000	LABORATORY	0.161557	200,913	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.264057	782,543	65.00
66.00	06600	PHYSICAL THERAPY	0.267121	626,350	66.00
68.00	06800	SPEECH PATHOLOGY	0.554324	106,453	68.00
69.00	06900	ELECTROCARDIOLOGY	0.024278	10,699	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.215502	94,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.359751	397,309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507283	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.146278	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606165	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,538,360	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,538,360	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/9/2021 8:08 am

		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)			2,667,094	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,166,493	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)			46,149	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			50,756	2.04
3.00	Managed Care Simulated Payments			145,951	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			40.17	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)			3.56	30.00
31.00	Percentage of Medicaid patient days (see instructions)			25.55	31.00
32.00	Sum of lines 30 and 31			29.11	32.00
33.00	Allowable disproportionate share percentage (see instructions)			9.88	33.00
34.00	Disproportionate share adjustment (see instructions)			94,690	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/9/2021 8:08 am	
		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)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000026433	0.000051886	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		220,731	430,139	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		165,247	108,419	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		273,666		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,298,848		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		4,274,939		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			4,298,848	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			297,038	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			87,472	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)			4,683,358	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			4,683,358	61.00
62.00	Deductibles billed to program beneficiaries			547,448	62.00
63.00	Coinurance billed to program beneficiaries			7,744	63.00
64.00	Allowable bad debts (see instructions)			114,540	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			74,451	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			90,903	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,202,617	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)			-21,490	70.93
70.94	HRR adjustment amount (see instructions)			4,417	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/9/2021 8:08 am
		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	679,338	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	328,989	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		56,746	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,137,125	71.00
71.01	Sequestration adjustment (see instructions)		33,905	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		5,061,668	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)		41,552	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		0	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/9/2021 8:08 am

		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	2,667,094	0	2,667,094		2,667,094
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,166,493	0		1,166,493	1,166,493
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	46,149	0	46,149		46,149
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	50,756	0		50,756	50,756
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	145,951	0	145,951	0	145,951
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	0.0988	0.0988	0.0988	0.0988	
11.00	Disproportionate share adjustment (see instructions)	34.00	94,690	0	65,877	28,813	94,690
11.01	Uncompensated care payments	36.00	273,666	0	165,247	108,419	273,666
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	4,298,848	0	2,944,367	1,354,481	4,298,848
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	4,298,848	0	2,944,367	1,354,481	4,298,848
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	297,038	0	210,943	86,095	297,038

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/9/2021 8:08 am

				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	
17.00	Special add-on payments for new technologies	54.00	87,472	0	0	87,472	87,472	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,155,310	1,528,048	4,683,358	19.00
		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	291,718	0	208,176	83,542	291,718	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,320	0	2,767	2,553	5,320	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	297,038	0	210,943	86,095	297,038	26.00
		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				0.215300	0.215300		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			679,338		679,338	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				328,989	328,989	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/9/2021 8:08 am

		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	2,667,094	2,667,094		2,667,094	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,166,493		1,166,493	1,166,493	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	46,149	46,149		46,149	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	50,756		50,756	50,756	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	145,951	145,951	0	145,951	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	0.0988	0.0988	0.0988		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	94,690	65,877	28,813	94,690	11.00
11.01	Uncompensated care payments	36.00	273,666	165,247	108,419	273,666	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	4,298,848	2,944,367	1,354,481	4,298,848	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	4,298,848	2,944,367	1,354,481	4,298,848	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	297,038	210,963	86,075	297,038	16.00
17.00	Special add-on payments for new technologies	54.00	87,472	0	87,472	87,472	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			3,155,330	1,528,028	4,683,358	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/9/2021 8:08 am

		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	291,718	208,176	83,542	291,718	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	5,320	2,787	2,533	5,320	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	297,038	210,963	86,075	297,038	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	679,338	679,338		679,338	28.00
29.00	Low volume adjustment on or after October 1	70.97	328,989		328,989	328,989	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-21,490	-17,603	-3,887	-21,490	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	4,417	0	4,417	4,417	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		38,171	18,575	56,746	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			1,121	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,299,708	2.00
3.00	OPPS payments			3,448,121	3.00
4.00	Outlier payment (see instructions)			3,939	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)			1,121	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			3,117	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)			3,117	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)			3,117	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			1,996	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)			1,121	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)			3,452,060	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)			695,511	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,757,670	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2,757,670	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			2,757,670	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)			124,341	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			80,822	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			84,770	36.00
37.00	Subtotal (see instructions)			2,838,492	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)			2,838,492	40.00
40.01	Sequestration adjustment (see instructions)			18,734	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			2,813,244	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)			6,514	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: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/9/2021 8:08 am

		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		5,131,674		2,882,726	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	11/30/2020	70,006	11/30/2020	69,482	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)		-70,006		-69,482	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)		5,061,668		2,813,244	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		41,552		6,514	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,103,220		2,819,758	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: 14-0147

Period:

Worksheet E-1

Component CCN: 14-U147

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

7/9/2021 8:08 am

		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		755,574		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)		755,574		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		2,834		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		758,408		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/9/2021 8:08 am
		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: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2	
		Component CCN: 14-U147		Date/Time Prepared: 7/9/2021 8:08 am	
		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)		813,220	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		1,482	1,482	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)		813,220	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		813,220	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)		813,220	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		50,688	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		762,532	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)		1,408	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		915	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		763,447	0	19.00
19.01	Sequestration adjustment (see instructions)		5,039	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		755,574	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)		2,834	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/9/2021 8:08 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		0	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		0.000000	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		0	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		0	18.00
19.00	Deductibles		0	19.00
20.00	Subtotal (line 18 minus line 19)		0	20.00
21.00	Coinurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		0	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		0	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		0	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 7/9/2021 8:08 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
7/9/2021 8:08 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	23,021,800	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,272,283	0	0	0	4.00
5.00	Other receivable	247,890	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,709,525	0	0	0	6.00
7.00	Inventory	893,260	0	0	0	7.00
8.00	Prepaid expenses	211,758	0	0	0	8.00
9.00	Other current assets	-1,961,468	0	0	0	9.00
10.00	Due from other funds	1,123,029	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32,099,027	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,005,119	0	0	0	12.00
13.00	Land improvements	549,876	0	0	0	13.00
14.00	Accumulated depreciation	-432,728	0	0	0	14.00
15.00	Buildings	33,261,042	0	0	0	15.00
16.00	Accumulated depreciation	-20,472,672	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	129,811	0	0	0	21.00
22.00	Accumulated depreciation	-92,505	0	0	0	22.00
23.00	Major movable equipment	27,347,322	0	0	0	23.00
24.00	Accumulated depreciation	-20,386,425	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)	20,908,840	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	435,621	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	435,621	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,443,488	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	884,470	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,049,973	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,275,884	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,210,327	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	230,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,335	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	254,335	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,464,662	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	34,978,826				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	34,978,826	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,443,488	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/9/2021 8:08 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		7,837,142		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,225,065				2.00
3.00	Total (sum of line 1 and line 2)		2,612,077		0		3.00
4.00	RECONCILING ITEM	32,366,749		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)		32,366,749		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,978,826		0		11.00
12.00	RECONCILING ITEM	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,978,826		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	RECONCILING ITEM		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	RECONCILING ITEM		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,397,836		6,397,836	1.00
2.00	SUBPROVIDER - IPF	0		0	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	1,238,178		1,238,178	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)	7,636,014		7,636,014	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,723,021		2,723,021	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)	2,723,021		2,723,021	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,359,035		10,359,035	17.00
18.00	Ancillary services	22,256,097	102,895,344	125,151,441	18.00
19.00	Outpatient services	2,337,609	18,936,188	21,273,797	19.00
20.00	RURAL HEALTH CLINIC	0	2,120,987	2,120,987	20.00
20.01	RURAL HEALTH CLINIC II	0	1,940,807	1,940,807	20.01
20.02	RURAL HEALTH CLINIC III	0	2,528,104	2,528,104	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		364,592	364,592	22.00
23.00	AMBULANCE SERVICES	0	155,272	155,272	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	3,044	691,041	694,085	26.00
27.00	PHYS PRIVATE OFFICES AND PRO FEE	102,371	9,364,182	9,466,553	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	35,058,156	138,996,517	174,054,673	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,271,879		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)		61,271,879		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/9/2021 8:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	174,054,673	1.00
2.00	Less contractual allowances and discounts on patients' accounts	127,481,926	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,572,747	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,271,879	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,699,132	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	38,866	6.00
7.00	Income from investments	106,097	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	106,467	13.00
14.00	Revenue from meals sold to employees and guests	196,869	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	9,749	21.00
22.00	Rental of hospital space	91,964	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	26,142	24.00
24.50	COVID-19 PHE Funding	8,897,913	24.50
25.00	Total other income (sum of lines 6-24)	9,474,067	25.00
26.00	Total (line 5 plus line 25)	-5,225,065	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)	-5,225,065	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0147
HHA CCN: 14-7187
Period: From 01/01/2020 To 12/31/2020
Worksheet H
Date/Time Prepared: 7/9/2021 8:08 am

				Home Health Agency I		PPS	
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
		1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0
2.00	Capital Related - Movable Equipment			0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0	0
4.00	Transportation	0	0	0	0	0	0
5.00	Administrative and General	0	0	0	0	0	0
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	210,954	73,654	23,947	1,869	33,344	343,768
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	210,954	73,654	23,947	1,869	33,344	343,768
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	343,768	0	343,768		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	0	0	0		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	343,768	0	343,768		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0147

Period:

Worksheet H-1

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/9/2021 8:08 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	343,768	0	0	0	0	343,768	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	343,768	0	0	0	0	343,768	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	0						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	343,768					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		343,768					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet H-1

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/9/2021 8:08 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	343,768	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	343,768	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	343,768	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

7/9/2021 8:08 am

Home Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	343,768	7,897	0	0	351,665	131,737	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	343,768	7,897	0	0	351,665	131,737	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	17,918	14,628	0	32,671	0	37,618	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	17,918	14,628	0	32,671	0	37,618	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

7/9/2021 8:08 am

Home Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	3,585	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	3,585	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		19.00	20.00	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	589,822	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	589,822	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/9/2021 8:08 amHome Health
Agency I

PPS

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	589,822	0	589,822			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	589,822	0	589,822			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0147
HHA CCN: 14-7187Period:
From 01/01/2020
To 12/31/2020Worksheet H-2
Part II
Date/Time Prepared:
7/9/2021 8:08 am

						Home Health Agency I	PPS
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)				
		1.00	2.00	4.00	5A	5.00	6.00
1.00	Administrative and General	0	0	0	0	0	0
2.00	Skilled Nursing Care	1,333	70	210,954	0	351,665	1,333
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	1,333	70	210,954		351,665	1,333
21.00	Total cost to be allocated	7,897	0	0		131,737	17,918
22.00	Unit cost multiplier	5.924231	0.000000	0.000000		0.374609	13.441860
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY MEALS SERV)	CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)
		7.00	8.00	9.00	10.00	11.00	12.00
1.00	Administrative and General	0	0	0	0	0	0
2.00	Skilled Nursing Care	1,333	0	156	0	6,949	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	1,333	0	156	0	6,949	0
21.00	Total cost to be allocated	14,628	0	32,671	0	37,618	0
22.00	Unit cost multiplier	10.973743	0.000000	209.429487	0.000000	5.413441	0.000000

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE Agency I (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	10,124	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	10,124	0	0	0	0	20.00
21.00	Total cost to be allocated	0	3,585	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.354109	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)			
		20.00	21.00	22.00	23.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/9/2021 8:08 am

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	589,822		589,822	1,535	384.25	1.00
2.00	Physical Therapy	3.00	0	0	0	781	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	186	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	27	0.00	4.00
5.00	Medical Social Services	6.00	0		0	11	0.00	5.00
6.00	Home Health Aide	7.00	0		0	435	0.00	6.00
7.00	Total (sum of lines 1-6)		589,822	0	589,822	2,975		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,059			8.00
9.00	Physical Therapy		99914	0	657			9.00
10.00	Occupational Therapy		99914	0	161			10.00
11.00	Speech Pathology		99914	0	27			11.00
12.00	Medical Social Services		99914	0	9			12.00
13.00	Home Health Aide		99914	0	159			13.00
14.00	Total (sum of lines 8-13)			0	2,072			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Part A	Program Visits		Cost of Services			
			Part B					
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,059		0	406,921		1.00
2.00	Physical Therapy	0	657		0	0		2.00
3.00	Occupational Therapy	0	161		0	0		3.00
4.00	Speech Pathology	0	27		0	0		4.00
5.00	Medical Social Services	0	9		0	0		5.00
6.00	Home Health Aide	0	159		0	0		6.00
7.00	Total (sum of lines 1-6)	0	2,072		0	406,921		7.00
Cost Center Description								
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

7/9/2021 8:08 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B	Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation								
1.00	Skilled Nursing Care	406,921						1.00
2.00	Physical Therapy	0						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	406,921						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/9/2021 8:08 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.267121	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology	68.00	0.554324	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.215502	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.507283	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 HHA CCN: 14-7187	Period: From 01/01/2020 To 12/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	607,799	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	607,799	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	607,799	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	280,419	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	38,212	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	4,832	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	5,704	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	12,849	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	342,016	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	342,016	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	342,016	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	342,016	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	342,016	31.00
31.01	Sequestration adjustment (see instructions)		0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	335,177	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	6,839	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0147
HHA CCN: 14-7187Period:
From 01/01/2020
To 12/31/2020Worksheet H-5
Date/Time Prepared:
7/9/2021 8:08 am

		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		0		335,177	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			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			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. H-4, Part II, column as appropriate, line 32)		0		335,177	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		6,839	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		342,016	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

				Hospice I		7/9/2021 8:00 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	11,586	143,033	154,619	0	154,619	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	44,447	0	44,447	0	44,447	28.00
29.00	LPN/LVN**	8,684	0	8,684	0	8,684	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	25,288	0	25,288	0	25,288	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	90,005	143,033	233,038	0	233,038	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	154,619	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	44,447	28.00
29.00	LPN/LVN**	0	8,684	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	25,288	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	233,038	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0147

Period:

Worksheet 0-2

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

					Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL		
		1.00	2.00	3.00	4.00	5.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00	
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00	
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00	
28.00	REGISTERED NURSE	44,447	0	44,447	0	44,447	28.00	
29.00	LPN/LVN	8,684	0	8,684	0	8,684	29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00	
34.00	SPIRITUAL COUNSELING	25,288	0	25,288	0	25,288	34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00	IMAGING SERVICES	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00	
100.00	TOTAL *	78,419	0	78,419	0	78,419	100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	44,447	28.00
29.00	LPN/LVN	0	8,684	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	25,288	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	78,419	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0147

Period:

Worksheet 0-5

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	7,897	7,897	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL	154,619	138,896	293,515	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	32,671	32,671	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	677	677	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	78,419	0	78,419	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	233,038	180,141	413,179	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
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Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	7,897	7,897					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0			3.00
4.00	ADMINISTRATIVE & GENERAL	293,515	0	0	0		293,515	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	7,897	0	0		7,897	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0		0	6.00
7.00	HOUSEKEEPING	32,671	0	0	0		32,671	7.00
8.00	DIETARY	0	0	0	0		0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	677	0	0	0		677	10.00
11.00	MEDICAL RECORDS	0	0	0	0		0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0		0	13.00
14.00	PHARMACY	0	0	0	0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0		0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	78,419				0	78,419	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	0	99.00
100.00	TOTAL	413,179	7,897	0	0	0	413,179	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2020
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Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	293,515						4.00
5.00	PLANT OPERATION & MAINTENANCE	19,370	27,267					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	80,136	0			112,807		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,661	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	0	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	192,348						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	27,267		0	112,807	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	293,515	27,267		0	112,807	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

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Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	2,338				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0				0	13.00
14.00	PHARMACY	0				0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				0	15.00
16.00	OTHER GENERAL SERVICE	0				0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	2,338	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	2,338	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

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Hospice CCN: 14-1542

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Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		273,105	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	140,074	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	413,179	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2020
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Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,333					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-293,515	119,664	4.00
5.00	PLANT OPERATION & MAINTENANCE	1,333	0	0	0	7,897	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	32,671	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	677	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	78,419	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	7,897	0	0		293,515	100.00
101.00	UNIT COST MULTIPLIER	5.924231	0.000000	0.000000		2.452826	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	156					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		156			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	156	0	156	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	27,267	0	112,807	0	0	100.00
101.00	UNIT COST MULTIPLIER	174.788462	0.000000	723.121795	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

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Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,687					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,687	0	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER			0	0	0	99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	2,338	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.385892	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/9/2021 8:08 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0	0		99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0147

Period:

Worksheet 0-7

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020

Date/Time Prepared:
7/9/2021 8:08 am

					Hospice I		
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1.00	PHYSICAL THERAPY	66.00	0.267121	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00	0.554324	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.507283	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.161557	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.215502	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	93.99	0.000000	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.97	CARDIAC REHABILITATION	76.97	0.000000	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98	0.000000	0	0	0	10.98
10.99	LITHOTRIPSY	76.99	0.000000	0	0	0	10.99
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service		Costs by LOC		
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	10.98
10.99	LITHOTRIPSY	0	0	0	0	0	10.99
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0147

Period:

Worksheet 0-8

Hospice CCN: 14-1542

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			273,105	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,687	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			161.89	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,687	0		9.00
10.00	Program cost (line 8 times line 9)	273,108	0		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			140,074	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			413,179	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,687	22.00
23.00	Average cost per diem (line 21 divided by line 22)			244.92	23.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0147

Period:
From 01/01/2020
To 12/31/2020Worksheet L
Parts I-III
Date/Time Prepared:
7/9/2021 8:08 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	291,718	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,320	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)	10.16	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)	297,038	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: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,507	0	110,507	0	110,507	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	163,617	0	163,617	0	163,617	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	274,124	0	274,124	0	274,124	10.00
11.00	Physician Services Under Agreement	0	437,930	437,930	0	437,930	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	437,930	437,930	0	437,930	14.00
15.00	Medical Supplies	0	9,546	9,546	0	9,546	15.00
16.00	Transportation (Health Care Staff)	0	5,810	5,810	0	5,810	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	52,307	52,307	0	52,307	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	67,663	67,663	0	67,663	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	274,124	505,593	779,717	0	779,717	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	46,561	46,561	0	46,561	29.00
30.00	Administrative Costs	130,993	127,316	258,309	151,419	409,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	130,993	173,877	304,870	151,419	456,289	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	405,117	679,470	1,084,587	151,419	1,236,006	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	110,507	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	163,617	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	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	274,124	10.00
11.00	Physician Services Under Agreement	0	437,930	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	437,930	14.00
15.00	Medical Supplies	0	9,546	15.00
16.00	Transportation (Health Care Staff)	0	5,810	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	52,307	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	67,663	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	779,717	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	46,561	29.00
30.00	Administrative Costs	22,970	432,698	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	22,970	479,259	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	22,970	1,258,976	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2020

Date/Time Prepared:

To 12/31/2020

7/9/2021 8:08 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	315,411	0	315,411	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	91,680	0	91,680	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	407,091	0	407,091	0	10.00
11.00	Physician Services Under Agreement	0	700,011	700,011	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	700,011	700,011	0	14.00
15.00	Medical Supplies	0	1,741	1,741	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	12,525	12,525	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,266	14,266	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	407,091	714,277	1,121,368	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	36,650	36,650	0	29.00
30.00	Administrative Costs	51,309	117,028	168,337	138,556	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	51,309	153,678	204,987	138,556	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	458,400	867,955	1,326,355	138,556	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	315,411	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	91,680	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	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	407,091	10.00
11.00	Physician Services Under Agreement	0	700,011	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	700,011	14.00
15.00	Medical Supplies	0	1,741	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	12,525	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,266	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,121,368	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	36,650	29.00
30.00	Administrative Costs	23,268	330,161	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,268	366,811	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	23,268	1,488,179	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2020

Date/Time Prepared:

To 12/31/2020

7/9/2021 8:08 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	36,418	0	36,418	0	36,418
3.00	Nurse Practitioner	573,215	0	573,215	0	573,215
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	276,135	0	276,135	0	276,135
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	11,348	0	11,348	0	11,348
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	897,116	0	897,116	0	897,116
11.00	Physician Services Under Agreement	0	328,183	328,183	0	328,183
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	328,183	328,183	0	328,183
15.00	Medical Supplies	0	11,941	11,941	0	11,941
16.00	Transportation (Health Care Staff)	0	6,247	6,247	0	6,247
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	109,180	109,180	0	109,180
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	127,368	127,368	0	127,368
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	897,116	455,551	1,352,667	0	1,352,667
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	104,398	104,398	0	104,398
30.00	Administrative Costs	343,275	302,586	645,861	180,483	826,344
31.00	Total Facility Overhead (sum of lines 29 and 30)	343,275	406,984	750,259	180,483	930,742
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,240,391	862,535	2,102,926	180,483	2,283,409

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	36,418	2.00
3.00	Nurse Practitioner	0	573,215	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	276,135	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	11,348	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	897,116	10.00
11.00	Physician Services Under Agreement	0	328,183	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	328,183	14.00
15.00	Medical Supplies	0	11,941	15.00
16.00	Transportation (Health Care Staff)	0	6,247	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	109,180	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	127,368	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,352,667	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	104,398	29.00
30.00	Administrative Costs	25,322	851,666	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,322	956,064	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	25,322	2,308,731	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8548

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.87	2,000	4,200	3,654		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.86	3,762	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.73	5,762		5,460	5,762	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.73	5,762			5,762	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)					779,717	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					779,717	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					479,259	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					929,424	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,408,683	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,408,683	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,408,683	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,188,400	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8586

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.87	4,000	2,800	2,436
2.00	Physician Assistant	0.00	0	0	0
3.00	Nurse Practitioner	2.26	1,222	1,400	3,164
4.00	Subtotal (sum of lines 1 through 3)	3.13	5,222	5,600	5,600
5.00	Visiting Nurse	0.00	0	0	0
6.00	Clinical Psychologist	0.00	0	0	0
7.00	Clinical Social Worker	0.00	0	0	0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0	0	0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0	0	0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.13	5,222		5,600
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,121,368
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,121,368
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				366,811
15.00	Parent provider overhead allocated to facility (see instructions)				917,214
16.00	Total overhead (sum of lines 14 and 15)				1,284,025
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				1,284,025
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,284,025
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,405,393

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8584

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/9/2021 8:08 am

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	1.26	4,000	4,200	5,292
2.00	Physician Assistant	0.00	0	0	0
3.00	Nurse Practitioner	3.97	6,508	2,100	8,337
4.00	Subtotal (sum of lines 1 through 3)	5.23	10,508	13,629	13,629
5.00	Visiting Nurse	0.00	0	0	0
6.00	Clinical Psychologist	0.00	0	0	0
7.00	Clinical Social Worker	0.00	0	0	0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0	0	0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0	0	0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.23	10,508		13,629
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,352,667
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,352,667
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				956,064
15.00	Parent provider overhead allocated to facility (see instructions)				1,994,640
16.00	Total overhead (sum of lines 14 and 15)				2,950,704
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				2,950,704
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,950,704
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,303,371

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8548		Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,188,400	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			317,826	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,870,574	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,762	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,762	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			324.64	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		324.64	324.64	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,309	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	749,594	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	749,594	16.00
16.01	Total program charges (see instructions)(from contractor's records)			509,880	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			558,625	16.04
16.05	Total program cost (see instructions)		0	558,625	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			51,313	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			89,588	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			558,625	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			184,033	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			742,658	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			742,658	26.00
26.01	Sequestration adjustment (see instructions)			4,902	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			503,564	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)			234,192	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8586		Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,405,393	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			208,093	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,197,300	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,600	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,600	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			392.38	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		392.38	392.38	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,209	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	866,767	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	866,767	16.00
16.01	Total program charges (see instructions)(from contractor's records)			499,082	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			664,045	16.04
16.05	Total program cost (see instructions)		0	664,045	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			36,711	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			89,681	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			664,045	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			122,500	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			786,545	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			786,545	26.00
26.01	Sequestration adjustment (see instructions)			5,191	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			446,480	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)			334,874	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8584		Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	RHC III	Cost	
			1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,303,371	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			117,857	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,185,514	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,629	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)			13,629	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			307.10	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		307.10	307.10	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,010	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	310,171	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	310,171	16.00
16.01	Total program charges (see instructions)(from contractor's records)			202,604	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			221,783	16.04
16.05	Total program cost (see instructions)		0	221,783	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			32,942	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			33,037	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			221,783	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			73,178	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			294,961	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			294,961	26.00
26.01	Sequestration adjustment (see instructions)			1,947	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			37,051	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)			255,963	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: 14-0147 Component CCN: 14-8548	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/9/2021 8:08 am	
		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)		274,124	274,124	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.035085	0.061726	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		9,618	16,921	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		58,588	28,113	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		68,206	45,034	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		779,717	779,717	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,408,683	1,408,683	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.087475	0.057757	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		123,225	81,361	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		191,431	126,395	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		536	943	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		357.15	134.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		301	571	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		107,502	76,531	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)			317,826	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)			184,033	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		407,091	407,091	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.035734	0.091114	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		14,547	37,092	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		30,096	15,276	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		44,643	52,368	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,121,368	1,121,368	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,284,025	1,284,025	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.039811	0.046700	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		51,118	59,964	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		95,761	112,332	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		251	640	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		381.52	175.52	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		132	411	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		50,361	72,139	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)			208,093	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)			122,500	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/9/2021 8:08 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		897,116	897,116	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003253	0.019575	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,918	17,561	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,189	8,378	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		11,107	25,939	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,352,667	1,352,667	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,950,704	2,950,704	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008211	0.019176	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		24,228	56,583	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		35,335	82,522	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		56	337	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		630.98	244.87	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		24	237	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		15,144	58,034	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)			117,857	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)			73,178	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/9/2021 8:08 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			478,991	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			11/30/2020	24,573	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)			24,573	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			503,564	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			234,192	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			737,756	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/9/2021 8:08 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			354,816	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			11/30/2020	91,664	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)			91,664	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			446,480	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			334,874	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			781,354	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/9/2021 8:08 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			98,087	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			11/30/2020	61,036	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)			-61,036	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			37,051	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			255,963	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			293,014	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00