

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: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 10:31 am
--	-----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date: 8/2/2021 Time: 10:31 am
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 CROSSROADS COMMUNITY HOSPITAL (14-0294) 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) RICK SCHUMACHER
 Officer or Administrator of Provider(s)

CFO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title XVIII			HIT	Title XIX	
		Title V	Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	-175,454	20,573	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		105,852		0	10.00
10.01	RURAL HEALTH CLINIC II	0		21,370		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-105,087		0	10.02
200.00	Total	0	-175,454	42,708	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: 14-0294		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:31 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8 DOCTORS PARK ROAD			PO Box:				1.00			
2.00	City: MT VERNON			State: IL		Zip Code: 62864		County: JEFFERSON 2.00			
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
									V	XVIII	
									XIX		
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF			CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	N
8.00	Swing Beds - NF										6.00
9.00	Hospital-Based SNF										7.00
10.00	Hospital-Based NF										8.00
11.00	Hospital-Based OLTC										9.00
12.00	Hospital-Based HHA										10.00
13.00	Separately Certified ASC										11.00
14.00	Hospital-Based Hospice										12.00
15.00	Hospital-Based Health Clinic - RHC			CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N
15.01	Hospital-Based Health Clinic - RHC II			CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N
15.02	Hospital-Based Health Clinic - RHC III			CROSSROADS INTERNAL MEDICINE RHC	148605	99914		11/20/2019	N	O	N
16.00	Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospital-Based (CMHC) I										15.01
18.00	Renal Dialysis										15.02
19.00	Other										16.00
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2020	12/31/2020		
21.00	Type of Control (see instructions)							4			
								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			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y			
22.02	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			
22.03	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		
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/2/2021 10:31 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	61	0	0	0	214	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					01/01/2020	12/31/2020	38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:31 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
61.01	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)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/2/2021 10:31 am

	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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
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: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:31 am
			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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	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	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	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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	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
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N
				110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:31 am
		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		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	87,918	139,800	0118.01
		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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
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	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0294		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 10:31 am	
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: QUORUM GROUP CORPORATION		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280				141.00
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100						142.00
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				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.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								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
									171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 10:31 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/01/2021	Y
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: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 10:31 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINTON	BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3869	CBALLEW@QHCUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/2/2021 10:31 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:31 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	40	14,640	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)		40	14,640	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,562	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						13.00
14.00 Total (see instructions)		47	17,202	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 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)		47				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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:31 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)	1,330	61	2,305			1.00
2.00	HMO and other (see instructions)	126	214				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,330	61	2,305			7.00
8.00	INTENSIVE CARE UNIT	59	0	154			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)	1,389	61	2,459	0.00	160.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	682	0	1,735	0.00	3.05	26.00
26.01	RURAL HEALTH CLINIC II	1,454	0	3,036	0.00	2.36	26.01
26.02	RURAL HEALTH CLINIC III	3,554	0	9,039	0.00	15.97	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	181.80	27.00
28.00	Observation Bed Days		0	424			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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 10:31 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	473	10	899	1.00
2.00 HMO and other (see instructions)			45	85		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	473	10	899	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 10:31 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	12,752,742	0	12,752,742	378,098.00	33.73
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
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		873,597	0	873,597	5,774.00	151.30
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		725,895	0	725,895	12,416.00	58.46
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	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		38,948	49,411	88,359	2,377.00	37.17
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		57,136	0	57,136	122.00	468.33
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		742,392	0	742,392	11,473.00	64.71
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)		2,672,429	0	2,672,429		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		19,518	0	19,518		
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		69,822	0	69,822		
24.00	Wage-related costs (RHC/FQHC)		125,183	0	125,183		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 10:31 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	190,919	0	190,919	5,788.00	32.99	26.00
27.00	Administrative & General	5.00	1,534,586	-49,411	1,485,175	33,335.00	44.55	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	409,911	0	409,911	16,815.00	24.38	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	373,381	0	373,381	24,632.00	15.16	32.00
33.00	Housekeeping under contract (see instructions)		42,630	0	42,630	2,707.00	15.75	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		590,689	0	590,689	35,713.00	16.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	813,459	0	813,459	20,695.00	39.31	38.00
39.00	Central Services and Supply	14.00	239,012	0	239,012	12,371.00	19.32	39.00
40.00	Pharmacy	15.00	401,787	0	401,787	6,157.00	65.26	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
8/2/2021 10:31 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)	11,786,569	0	11,786,569	398,328.00	29.59	1.00
2.00	Excluded area salaries (see instructions)	38,948	49,411	88,359	2,377.00	37.17	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,747,621	-49,411	11,698,210	395,951.00	29.54	3.00
4.00	Subtotal other wages & related costs (see inst.)	799,528	0	799,528	11,595.00	68.95	4.00
5.00	Subtotal wage-related costs (see inst.)	2,672,429	0	2,672,429	0.00	22.84	5.00
6.00	Total (sum of lines 3 thru 5)	15,219,578	-49,411	15,170,167	407,546.00	37.22	6.00
7.00	Total overhead cost (see instructions)	4,596,374	-49,411	4,546,963	158,213.00	28.74	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
8/2/2021 10:31 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	146,282	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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,611,727	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	9,999	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,379	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-1,124	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	10,989	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	178,596	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	707,008	17.00
18.00	Medicare Taxes - Employers Portion Only	165,349	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	55,506	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,893,711	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: 14-0294

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 8/2/2021 10:31 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	57,136	2,893,711	1.00
2.00	Hospital	57,136	2,893,711	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
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
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0294 Component CCN: 14-8524		Period: From 01/01/2020 To 12/31/2020
			Worksheet S-8		Date/Time Prepared: 8/2/2021 10:31 am
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		3050 BROADWAY		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		MT.VERNON IL 62864		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
			from	to	from
			1.00	2.00	3.00
			Tuesday		from
			5.00		
11.00	Facility hours of operations (1)				
	CLINIC		08:00	16:30	08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			3.00		4.00
			Total Visits		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)				
			County		4.00
2.00	City, State, ZIP Code, County		JEFFERSON		
			Tuesday		wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			10.00		
11.00	Facility hours of operations (1)				
	CLINIC		16:30	08:00	16:30
			08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294

Period:

Worksheet S-8

Component CCN: 14-8524

From 01/01/2020

To 12/31/2020

Date/Time Prepared:
8/2/2021 10:31 am

RHC I

Cost

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

Health Financial Systems		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0294 Component CCN: 14-8523		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 8/2/2021 10:31 am	
		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1209 W ROBINSON		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WAYNE CITY		IL 62864	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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:30	08:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			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	WAYNE		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	16:30	08:00	16:30	08:00
		12:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0294 Component CCN: 14-8523		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 8/2/2021 10:31 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	08:00	16:30						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0294 Component CCN: 14-8605		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 8/2/2021 10:31 am	
				RHC III		Cost			
				1.00					
1.00	Clinic Address and Identification			4101 N WATER TOWER PL				1.00	
	Street			City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			MT. VERNON		IL 62864		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			
4.00	Source of Federal Funds							4.00	
5.00	Community Health Center (Section 330(d), PHS Act)							5.00	
6.00	Migrant Health Center (Section 329(d), PHS Act)							6.00	
7.00	Health Services for the Homeless (Section 340(d), PHS Act)							7.00	
8.00	Appalachian Regional Commission							8.00	
9.00	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	
11.00	Facility hours of operations (1)			CLINIC		08:00 16:30		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	
				1.00		2.00		3.00	
						XIX		Total Visits	
						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			JEFFERSON				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1)			CLINIC		16:30 08:00		16:30 08:00	
						16:30		16:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0294 Component CCN: 14-8605		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 8/2/2021 10:31 am	
						RHC III		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0294

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

Worksheet S-10

Date/Time Prepared:
8/2/2021 10:31 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)		0.151534	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,148,622	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		170,345	5.00
6.00	Medicaid charges		4,396,891	6.00
7.00	Medicaid cost (line 1 times line 6)		666,278	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)	2,275,705	984	2,276,689
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	344,847	984	345,831
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)	344,847	984	345,831
			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)		5,061,661	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		259,957	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		399,935	27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,661,726	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		846,388	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,192,219	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,192,219	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0294

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

Worksheet A

Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		504,197	504,197	396,557	900,754	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		980,179	980,179	4,788	984,967	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	190,919	34,992	225,911	2,061,116	2,287,027	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,534,586	13,595,647	15,130,233	-2,530,527	12,599,706	5.00
7.00	00700	OPERATION OF PLANT	409,911	1,127,384	1,537,295	-117,911	1,419,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,956	93,956	0	93,956	8.00
9.00	00900	HOUSEKEEPING	373,381	110,687	484,068	0	484,068	9.00
10.00	01000	DIETARY	0	821,861	821,861	-323,295	498,566	10.00
11.00	01100	CAFETERIA	0	0	0	323,295	323,295	11.00
13.00	01300	NURSING ADMINISTRATION	813,459	108,152	921,611	0	921,611	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	239,012	215,997	455,009	-133,106	321,903	14.00
15.00	01500	PHARMACY	401,787	1,676,140	2,077,927	-1,544,695	533,232	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,937	74,937	0	74,937	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,306,920	1,044,976	2,351,896	0	2,351,896	30.00
31.00	03100	INTENSIVE CARE UNIT	785,925	57,132	843,057	0	843,057	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,802,860	5,770,691	7,573,551	-1,830,299	5,743,252	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,109,089	1,109,089	0	1,109,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,572	536,586	1,119,158	0	1,119,158	54.00
54.01	03630	ULTRA SOUND	48,465	102,126	150,591	0	150,591	54.01
56.00	05600	RADIOISOTOPE	15,820	157,276	173,096	0	173,096	56.00
57.00	05700	CT SCAN	142,793	170,788	313,581	0	313,581	57.00
58.00	05800	MRI	46,609	393,591	440,200	0	440,200	58.00
60.00	06000	LABORATORY	675,753	739,881	1,415,634	0	1,415,634	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	304,641	57,613	362,254	0	362,254	65.00
66.00	06600	PHYSICAL THERAPY	86,545	461,635	548,180	-27,741	520,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,916	97,184	118,100	25,198	143,298	67.00
68.00	06800	SPEECH PATHOLOGY	2,370	9,135	11,505	2,543	14,048	68.00
69.00	06900	ELECTROCARDIOLOGY	174,241	48,421	222,662	0	222,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	331,817	331,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,749,499	1,749,499	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,544,695	1,544,695	73.00
74.00	07400	RENAL DIALYSIS	0	56,250	56,250	0	56,250	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	79,822	21,791	101,613	0	101,613	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,484,758	766,769	2,251,527	-1,921,377	330,150	88.00
88.01	08801	RURAL HEALTH CLINIC II	185,716	138,210	323,926	-32,081	291,845	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,725,031	1,725,031	88.02
91.00	09100	EMERGENCY	1,004,013	1,279,400	2,283,413	-1,277	2,282,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,713,794	32,362,673	45,076,467	-297,770	44,778,697	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,029	30,396	34,425	2,109	36,534	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	295,661	295,661	194.01
194.02	07954	SENIOR CIRCLE	34,919	10,636	45,555	0	45,555	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,752,742	32,403,705	45,156,447	0	45,156,447	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0294

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

Worksheet A

Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-124,899	775,855	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,763	982,204	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,287,027	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,697,764	7,901,942	5.00
7.00	00700	OPERATION OF PLANT	-4,249	1,415,135	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,956	8.00
9.00	00900	HOUSEKEEPING	0	484,068	9.00
10.00	01000	DIETARY	0	498,566	10.00
11.00	01100	CAFETERIA	-67,068	256,227	11.00
13.00	01300	NURSING ADMINISTRATION	0	921,611	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	321,903	14.00
15.00	01500	PHARMACY	0	533,232	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-40	74,897	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-743,022	1,608,874	30.00
31.00	03100	INTENSIVE CARE UNIT	-536,715	306,342	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-239,366	5,503,886	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	-1,046,693	62,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-101,111	1,018,047	54.00
54.01	03630	ULTRA SOUND	-700	149,891	54.01
56.00	05600	RADIOISOTOPE	0	173,096	56.00
57.00	05700	CT SCAN	-26,834	286,747	57.00
58.00	05800	MRI	0	440,200	58.00
60.00	06000	LABORATORY	-8,197	1,407,437	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	362,254	65.00
66.00	06600	PHYSICAL THERAPY	0	520,439	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	143,298	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,048	68.00
69.00	06900	ELECTROCARDIOLOGY	0	222,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	331,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,749,499	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,544,695	73.00
74.00	07400	RENAL DIALYSIS	0	56,250	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	101,613	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	330,150	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	291,845	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,725,031	88.02
91.00	09100	EMERGENCY	-1,066,179	1,215,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,665,600	36,113,097	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,534	192.00
194.00	07955	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	295,661	194.01
194.02	07954	SENIOR CIRCLE	0	45,555	194.02
194.03	07953	VACANT SPACE	0	0	194.03
194.04	07952	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,665,600	36,490,847	200.00

RECLASSIFICATIONS

Provider CCN: 14-0294

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 10:31 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,061,116		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,109		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	2,063,225		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	117,911		1.00
	0		0	117,911		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	396,557		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,788		2.00
	0		0	401,345		
	E - MARKETING					
1.00	MARKETING	194.01	49,411	246,250		1.00
	0		49,411	246,250		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	213,906		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,749,499		2.00
	0		0	1,963,405		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,544,695		1.00
	0		0	1,544,695		
	J - DIETARY					
1.00	CAFETERIA	11.00	0	323,295		1.00
	0		0	323,295		
	K - RECLASS SPEECH THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	2,140	23,058		1.00
2.00	SPEECH PATHOLOGY	68.00	79	2,464		2.00
	0		2,219	25,522		
	L - ATHENA BILLING AND COLLECTION SVCS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	128,255		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	128,255		
	M - RECLASS RHCIII FROM RHCI					
1.00	RURAL HEALTH CLINIC III	88.02	1,246,466	478,565		1.00
	TOTALS		1,246,466	478,565		
500.00	Grand Total: Increases		1,298,096	7,292,468		500.00

RECLASSIFICATIONS

Provider CCN: 14-0294

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 10:31 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,961,776	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	87,242	0	2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	13,656	0	3.00
4.00	EMERGENCY	91.00	0	551	0	4.00
			0	2,063,225		
B - OXYGEN SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	117,911	0	1.00
			0	117,911		
D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	401,345	12	1.00
2.00		0.00	0	0	13	2.00
			0	401,345		
E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	49,411	246,250	0	1.00
			49,411	246,250		
F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	133,106	0	1.00
2.00	OPERATING ROOM	50.00	0	1,830,299	0	2.00
			0	1,963,405		
G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	1,544,695	0	1.00
			0	1,544,695		
J - DIETARY						
1.00	DIETARY	10.00	0	323,295	0	1.00
			0	323,295		
K - RECLASS SPEECH THERAPY						
1.00	PHYSICAL THERAPY	66.00	2,219	25,522	0	1.00
2.00		0.00	0	0	0	2.00
			2,219	25,522		
L - ATHENA BILLING AND COLLECTION SVCS						
1.00	RURAL HEALTH CLINIC	88.00	0	109,104	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	18,425	0	2.00
3.00	EMERGENCY	91.00	0	726	0	3.00
			0	128,255		
M - RECLASS RHCIII FROM RHCI						
1.00	RURAL HEALTH CLINIC	88.00	1,246,466	478,565	0	1.00
	TOTALS		1,246,466	478,565		
500.00	Grand Total: Decreases		1,298,096	7,292,468		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/2/2021 10:31 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	1,640,000	0	0	0	0	1.00
2.00	Land Improvements	162,111	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,697,204	0	0	0	0	3.00
4.00	Building Improvements	37,301	0	0	0	0	4.00
5.00	Fixed Equipment	185,874	0	0	0	0	5.00
6.00	Movable Equipment	2,551,873	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,274,363	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,274,363	0	0	0	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,640,000	0				1.00
2.00	Land Improvements	162,111	0				2.00
3.00	Buildings and Fixtures	6,697,204	0				3.00
4.00	Building Improvements	37,301	0				4.00
5.00	Fixed Equipment	185,874	0				5.00
6.00	Movable Equipment	2,551,873	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	11,274,363	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	11,274,363	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/2/2021 10:31 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	504,197	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	980,179	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,484,376	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	504,197				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	980,179				2.00
3.00	Total (sum of lines 1-2)	0	1,484,376				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/2/2021 10:31 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	6,920,379	0	6,920,379	0.730595	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,551,873	0	2,551,873	0.269405	0	2.00
3.00	Total (sum of lines 1-2)	9,472,252	0	9,472,252	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	504,197	-124,899	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	977,416	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,481,613	-124,899	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	0	396,557	0	0	775,855	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	4,788	0	982,204	2.00
3.00	Total (sum of lines 1-2)	0	396,557	4,788	0	1,758,059	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0294

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 10:31 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-59,786	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,768,141			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-676	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,245,979			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,068	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		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-40	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0294

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 10:31 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 ADMIN & GENERAL ORGANIZATION COST	A	-152,489	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 MARKETING EXPENSE	A	-163,774	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 HEALTH WOMAN SPONSORSHIP	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 COUNTRY CLUB DUES	A	-15,860	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 PHYSICIAN RECRUITING	A	-81,599	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 LOBBYING EXPENSE	A	-4,523	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 PENALTIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 SPECIAL EVENTS	A	-67,554	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 MEDICAL STAFF RELATIONS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 ILLINOIS PROVIDER TAX	A	-2,377,850	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 GIFT SHOP EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 NON-ALLOWABLE LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13 TELEPHONE BENEFIT COSTS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14 TELEPHONE DEPRECIATION COST	A	-2,763	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15 TELEVISION EXPENSE	A	-4,249	OPERATION OF PLANT	7.00	0	33.15
33.21 RENTAL INCOME	B	-204,432	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22 OTHER MISCELLANEOUS REVENUE	B	-448,817	ADMINISTRATIVE & GENERAL	5.00	0	33.22
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,665,600				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0294

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

Worksheet A-8-1

Date/Time Prepared:
8/2/2021 10:31 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE BLDG & FIXED	79,533	0	1.00
2.00	0.00			0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	10,658	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OPERATING COSTS	30,154	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	POOLED NON-CAPITAL COSTS	532,310	1,755,849	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	-142,785	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			509,870	1,755,849	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	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		0.00	QHC	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: 14-0294

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

Worksheet A-8-1

Date/Time Prepared:
8/2/2021 10:31 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	79,533	10		1.00
2.00	0	9		2.00
3.00	10,658	0		3.00
4.00	30,154	0		4.00
4.01	-1,223,539	0		4.01
4.02	-142,785	0		4.02
5.00	-1,245,979			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	HOSPITAL MGMT		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: 14-0294

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

Worksheet A-8-2

Date/Time Prepared:
8/2/2021 10:31 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	30.00	ADULTS & PEDIATRICS	743,022	743,022	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	536,715	536,715	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	239,366	239,366	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,046,693	1,046,693	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	100,435	100,435	0	0	0	6.00
7.00	54.01	ULTRA SOUND	700	700	0	0	0	7.00
8.00	57.00	CT SCAN	26,834	26,834	0	0	0	8.00
9.00	60.00	LABORATORY	8,197	8,197	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	1,066,179	1,066,179	0	0	0	11.00
200.00			3,768,141	3,768,141	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	54.01	ULTRA SOUND	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	743,022		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	536,715		2.00
3.00	0.00		0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	239,366		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,046,693		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	100,435		6.00
7.00	54.01	ULTRA SOUND	0	0	0	700		7.00
8.00	57.00	CT SCAN	0	0	0	26,834		8.00
9.00	60.00	LABORATORY	0	0	0	8,197		9.00
10.00	0.00		0	0	0	0		10.00
11.00	91.00	EMERGENCY	0	0	0	1,066,179		11.00
200.00			0	0	0	3,768,141		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	775,855	775,855			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	982,204	982,204			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,287,027	4,960	6,279	2,298,266	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,901,942	82,871	104,911	271,722	8,361,446
7.00	00700	OPERATION OF PLANT	1,415,135	151,656	191,992	74,996	1,833,779
8.00	00800	LAUNDRY & LINEN SERVICE	93,956	3,401	4,306	0	101,663
9.00	00900	HOUSEKEEPING	484,068	25,570	32,370	68,312	610,320
10.00	01000	DIETARY	498,566	23,894	30,249	0	552,709
11.00	01100	CAFETERIA	256,227	0	0	0	256,227
13.00	01300	NURSING ADMINISTRATION	921,611	7,911	10,015	148,827	1,088,364
14.00	01400	CENTRAL SERVICES & SUPPLY	321,903	16,895	21,388	43,729	403,915
15.00	01500	PHARMACY	533,232	6,272	7,940	73,509	620,953
16.00	01600	MEDICAL RECORDS & LIBRARY	74,897	15,367	19,453	0	109,717
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,608,874	140,061	177,312	239,109	2,165,356
31.00	03100	INTENSIVE CARE UNIT	306,342	29,593	37,464	143,790	517,189
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,503,886	95,157	120,465	329,850	6,049,358
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	62,396	1,054	1,334	0	64,784
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,018,047	26,771	33,891	106,585	1,185,294
54.01	03630	ULTRA SOUND	149,891	3,136	3,970	8,867	165,864
56.00	05600	RADIOISOTOPE	173,096	2,631	3,331	2,894	181,952
57.00	05700	CT SCAN	286,747	0	0	26,125	312,872
58.00	05800	MRI	440,200	0	0	8,527	448,727
60.00	06000	LABORATORY	1,407,437	18,404	23,299	123,633	1,572,773
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	937	1,186	0	2,123
65.00	06500	RESPIRATORY THERAPY	362,254	8,416	10,655	55,736	437,061
66.00	06600	PHYSICAL THERAPY	520,439	3,395	4,298	15,428	543,560
67.00	06700	OCCUPATIONAL THERAPY	143,298	0	0	4,218	147,516
68.00	06800	SPEECH PATHOLOGY	14,048	0	0	448	14,496
69.00	06900	ELECTROCARDIOLOGY	222,662	0	0	31,878	254,540
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	331,817	0	0	0	331,817
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,749,499	0	0	0	1,749,499
73.00	07300	DRUGS CHARGED TO PATIENTS	1,544,695	0	0	0	1,544,695
74.00	07400	RENAL DIALYSIS	56,250	0	0	0	56,250
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	101,613	0	0	14,604	116,217
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	330,150	0	0	43,597	373,747
88.01	08801	RURAL HEALTH CLINIC II	291,845	0	0	33,978	325,823
88.02	08802	RURAL HEALTH CLINIC III	1,725,031	0	0	228,048	1,953,079
91.00	09100	EMERGENCY	1,215,957	38,706	49,000	183,690	1,487,353
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,113,097	707,058	895,108	2,282,100	35,941,038
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,372	3,003	0	5,375
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,534	2,304	2,917	737	42,492
194.00	07955	OTHER NRCC	0	0	0	0	0
194.01	07951	MARKETING	295,661	1,263	1,599	9,040	307,563
194.02	07954	SENIOR CIRCLE	45,555	3,327	4,212	6,389	59,483
194.03	07953	VACANT SPACE	0	59,531	75,365	0	134,896
194.04	07952	GUEST MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	36,490,847	775,855	982,204	2,298,266	36,490,847

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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	8,361,446					5.00
7.00	00700	OPERATION OF PLANT	545,089	2,378,868				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,219	15,084	146,966			8.00
9.00	00900	HOUSEKEEPING	181,417	113,406	0	905,143		9.00
10.00	01000	DIETARY	164,292	105,973	0	42,624	865,598	10.00
11.00	01100	CAFETERIA	76,163	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	323,515	35,087	0	14,113	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,063	74,930	0	30,138	0	14.00
15.00	01500	PHARMACY	184,578	27,819	0	11,189	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,613	68,153	0	27,412	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	643,650	621,190	48,501	249,854	790,364	30.00
31.00	03100	INTENSIVE CARE UNIT	153,734	131,250	8,817	52,791	63,609	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,798,175	422,033	29,394	169,749	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	19,257	4,673	0	1,880	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,327	118,734	8,817	47,757	0	54.00
54.01	03630	ULTRA SOUND	49,303	13,909	0	5,595	0	54.01
56.00	05600	RADIOISOTOPE	54,085	11,668	0	4,693	0	56.00
57.00	05700	CT SCAN	93,001	0	0	0	0	57.00
58.00	05800	MRI	133,384	0	0	0	0	58.00
60.00	06000	LABORATORY	467,505	81,625	0	32,831	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	631	4,154	0	1,671	0	62.00
65.00	06500	RESPIRATORY THERAPY	129,916	37,328	4,409	15,014	0	65.00
66.00	06600	PHYSICAL THERAPY	161,573	15,057	0	6,056	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,849	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,309	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75,662	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	98,632	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	520,037	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	459,159	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,720	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	34,545	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	111,096	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	96,851	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	580,551	0	0	0	0	88.02
91.00	09100	EMERGENCY	442,114	171,666	47,028	69,047	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,198,015	2,073,739	146,966	782,414	853,973	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,598	10,521	0	4,232	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,631	10,220	0	4,111	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	91,423	5,602	0	2,253	0	194.01
194.02	07954	SENIOR CIRCLE	17,681	14,756	0	5,935	0	194.02
194.03	07953	VACANT SPACE	40,098	264,030	0	106,198	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	11,625	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,361,446	2,378,868	146,966	905,143	865,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	332,390				11.00
13.00	01300	NURSING ADMINISTRATION	23,118	1,484,197			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,824	0	642,870		14.00
15.00	01500	PHARMACY	6,877	80,889	4,657	936,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	719	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,403	263,113	16,913	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,109	158,225	4,574	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	63,686	362,956	278,999	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	8,640	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,537	117,285	5,051	0	54.00
54.01	03630	ULTRA SOUND	1,580	9,757	1,144	0	54.01
56.00	05600	RADIOISOTOPE	558	3,185	342	0	56.00
57.00	05700	CT SCAN	5,716	28,748	4,450	0	57.00
58.00	05800	MRI	1,719	9,383	144	0	58.00
60.00	06000	LABORATORY	29,903	136,045	30,857	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	12,430	61,331	3,056	0	65.00
66.00	06600	PHYSICAL THERAPY	2,742	0	561	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	743	0	19	0	67.00
68.00	06800	SPEECH PATHOLOGY	70	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,595	35,079	101	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	28,065	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	228,180	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	936,962	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,672	16,070	1,637	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,086	0	1,605	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,483	0	1,976	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	37,105	0	8,364	0	88.02
91.00	09100	EMERGENCY	30,785	202,131	10,830	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	329,741	1,484,197	640,884	936,962	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	70	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	1,231	0	1,066	0	194.01
194.02	07954	SENIOR CIRCLE	1,348	0	920	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	332,390	1,484,197	642,870	936,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,847,499	0	4,847,499	30.00
31.00	03100	INTENSIVE CARE UNIT	1,098,900	0	1,098,900	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,230,016	0	9,230,016	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	125,980	0	125,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,866,417	0	1,866,417	54.00
54.01	03630	ULTRA SOUND	249,826	0	249,826	54.01
56.00	05600	RADIOISOTOPE	257,830	0	257,830	56.00
57.00	05700	CT SCAN	476,963	0	476,963	57.00
58.00	05800	MRI	597,971	0	597,971	58.00
60.00	06000	LABORATORY	2,387,757	0	2,387,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,002	0	9,002	62.00
65.00	06500	RESPIRATORY THERAPY	703,647	0	703,647	65.00
66.00	06600	PHYSICAL THERAPY	733,204	0	733,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,126	0	193,126	67.00
68.00	06800	SPEECH PATHOLOGY	18,981	0	18,981	68.00
69.00	06900	ELECTROCARDIOLOGY	380,630	0	380,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	459,291	0	459,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,516,618	0	2,516,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,949,844	0	2,949,844	73.00
74.00	07400	RENAL DIALYSIS	73,032	0	73,032	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	172,007	0	172,007	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	494,032	0	494,032	88.00
88.01	08801	RURAL HEALTH CLINIC II	430,685	0	430,685	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,581,693	0	2,581,693	88.02
91.00	09100	EMERGENCY	2,478,538	0	2,478,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,333,489	0	35,333,489	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,726	0	21,726	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,524	0	69,524	192.00
194.00	07955	OTHER NRCC	0	0	0	194.00
194.01	07951	MARKETING	409,138	0	409,138	194.01
194.02	07954	SENIOR CIRCLE	100,123	0	100,123	194.02
194.03	07953	VACANT SPACE	545,222	0	545,222	194.03
194.04	07952	GUEST MEALS	11,625	0	11,625	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,490,847	0	36,490,847	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
8/2/2021 10:31 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
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	4,960	6,279	11,239	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	82,871	104,911	187,782	5.00
7.00	00700	OPERATION OF PLANT	0	151,656	191,992	343,648	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,401	4,306	7,707	8.00
9.00	00900	HOUSEKEEPING	0	25,570	32,370	57,940	9.00
10.00	01000	DIETARY	0	23,894	30,249	54,143	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,911	10,015	17,926	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,895	21,388	38,283	14.00
15.00	01500	PHARMACY	0	6,272	7,940	14,212	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,367	19,453	34,820	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	140,061	177,312	317,373	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,593	37,464	67,057	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	95,157	120,465	215,622	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,054	1,334	2,388	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,771	33,891	60,662	54.00
54.01	03630	ULTRA SOUND	0	3,136	3,970	7,106	54.01
56.00	05600	RADIOISOTOPE	0	2,631	3,331	5,962	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	18,404	23,299	41,703	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	937	1,186	2,123	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,416	10,655	19,071	65.00
66.00	06600	PHYSICAL THERAPY	0	3,395	4,298	7,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	213	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	166	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,116	88.02
91.00	09100	EMERGENCY	0	38,706	49,000	87,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	707,058	895,108	1,602,166	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,372	3,003	5,375	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,304	2,917	5,221	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,263	1,599	2,862	194.01
194.02	07954	SENIOR CIRCLE	0	3,327	4,212	7,539	194.02
194.03	07953	VACANT SPACE	0	59,531	75,365	134,896	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	775,855	982,204	1,758,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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	189,111					5.00
7.00	00700	OPERATION OF PLANT	12,328	356,343				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	683	2,260	10,650			8.00
9.00	00900	HOUSEKEEPING	4,103	16,988	0	79,365		9.00
10.00	01000	DIETARY	3,716	15,874	0	3,737	77,470	10.00
11.00	01100	CAFETERIA	1,723	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,317	5,256	0	1,237	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,716	11,224	0	2,643	0	14.00
15.00	01500	PHARMACY	4,175	4,167	0	981	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	738	10,209	0	2,404	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,558	93,050	3,515	21,908	70,737	30.00
31.00	03100	INTENSIVE CARE UNIT	3,477	19,661	639	4,629	5,693	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,666	63,219	2,130	14,884	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	436	700	0	165	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,969	17,786	639	4,187	0	54.00
54.01	03630	ULTRA SOUND	1,115	2,084	0	491	0	54.01
56.00	05600	RADIOISOTOPE	1,223	1,748	0	412	0	56.00
57.00	05700	CT SCAN	2,103	0	0	0	0	57.00
58.00	05800	MRI	3,017	0	0	0	0	58.00
60.00	06000	LABORATORY	10,574	12,227	0	2,879	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14	622	0	146	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,938	5,592	319	1,316	0	65.00
66.00	06600	PHYSICAL THERAPY	3,654	2,255	0	531	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	992	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	97	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,711	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,231	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,762	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,385	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	378	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	781	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,513	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,191	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,131	0	0	0	0	88.02
91.00	09100	EMERGENCY	9,999	25,715	3,408	6,054	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	185,414	310,637	10,650	68,604	76,430	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36	1,576	0	371	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	286	1,531	0	360	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,068	839	0	198	0	194.01
194.02	07954	SENIOR CIRCLE	400	2,210	0	520	0	194.02
194.03	07953	VACANT SPACE	907	39,550	0	9,312	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	1,040	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	189,111	356,343	10,650	79,365	77,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,723					11.00
13.00	01300	NURSING ADMINISTRATION	120	32,584				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72	0	55,152			14.00
15.00	01500	PHARMACY	36	1,776	400	26,107		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	62	0	48,233	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	220	5,777	1,451	0	1,245	30.00
31.00	03100	INTENSIVE CARE UNIT	42	3,474	392	0	122	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	330	7,966	23,935	0	11,211	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	741	0	5,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117	2,575	433	0	1,743	54.00
54.01	03630	ULTRA SOUND	8	214	98	0	541	54.01
56.00	05600	RADIOISOTOPE	3	70	29	0	273	56.00
57.00	05700	CT SCAN	30	631	382	0	6,511	57.00
58.00	05800	MRI	9	206	12	0	934	58.00
60.00	06000	LABORATORY	155	2,987	2,647	0	7,329	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	86	62.00
65.00	06500	RESPIRATORY THERAPY	64	1,347	262	0	628	65.00
66.00	06600	PHYSICAL THERAPY	14	0	48	0	740	66.00
67.00	06700	OCCUPATIONAL THERAPY	4	0	2	0	202	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	21	68.00
69.00	06900	ELECTROCARDIOLOGY	55	770	9	0	942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,408	0	157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,576	0	3,825	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,107	1,827	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	13	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	14	353	140	0	175	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	37	0	138	0	101	88.00
88.01	08801	RURAL HEALTH CLINIC II	28	0	170	0	112	88.01
88.02	08802	RURAL HEALTH CLINIC III	192	0	718	0	525	88.02
91.00	09100	EMERGENCY	160	4,438	929	0	3,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,710	32,584	54,982	26,107	48,233	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	6	0	91	0	0	194.01
194.02	07954	SENIOR CIRCLE	7	0	79	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,723	32,584	55,152	26,107	48,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	531,004	0	531,004	30.00
31.00	03100	INTENSIVE CARE UNIT	105,889	0	105,889	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	381,573	0	381,573	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,842	0	9,842	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,632	0	96,632	54.00
54.01	03630	ULTRA SOUND	11,700	0	11,700	54.01
56.00	05600	RADIOISOTOPE	9,734	0	9,734	56.00
57.00	05700	CT SCAN	9,785	0	9,785	57.00
58.00	05800	MRI	4,220	0	4,220	58.00
60.00	06000	LABORATORY	81,106	0	81,106	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,991	0	2,991	62.00
65.00	06500	RESPIRATORY THERAPY	31,810	0	31,810	65.00
66.00	06600	PHYSICAL THERAPY	15,010	0	15,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,221	0	1,221	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	120	68.00
69.00	06900	ELECTROCARDIOLOGY	3,643	0	3,643	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,796	0	4,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,163	0	35,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,319	0	38,319	73.00
74.00	07400	RENAL DIALYSIS	391	0	391	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	1,534	0	1,534	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,002	0	3,002	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,667	0	2,667	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,682	0	15,682	88.02
91.00	09100	EMERGENCY	142,866	0	142,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,540,700	0	1,540,700	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,358	0	7,358	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,402	0	7,402	192.00
194.00	07955	OTHER NRCC	0	0	0	194.00
194.01	07951	MARKETING	6,108	0	6,108	194.01
194.02	07954	SENIOR CIRCLE	10,786	0	10,786	194.02
194.03	07953	VACANT SPACE	184,665	0	184,665	194.03
194.04	07952	GUEST MEALS	1,040	0	1,040	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,758,059	0	1,758,059	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0294

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,922					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		125,922				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	12,561,823			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,450	13,450	1,485,175	-8,361,446	28,129,401	5.00
7.00	00700	OPERATION OF PLANT	24,614	24,614	409,911	0	1,833,779	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	101,663	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	373,381	0	610,320	9.00
10.00	01000	DIETARY	3,878	3,878	0	0	552,709	10.00
11.00	01100	CAFETERIA	0	0	0	0	256,227	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	813,459	0	1,088,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	239,012	0	403,915	14.00
15.00	01500	PHARMACY	1,018	1,018	401,787	0	620,953	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	0	0	109,717	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,732	22,732	1,306,920	0	2,165,356	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	785,925	0	517,189	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,444	15,444	1,802,860	0	6,049,358	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	64,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	582,572	0	1,185,294	54.00
54.01	03630	ULTRA SOUND	509	509	48,465	0	165,864	54.01
56.00	05600	RADIOISOTOPE	427	427	15,820	0	181,952	56.00
57.00	05700	CT SCAN	0	0	142,793	0	312,872	57.00
58.00	05800	MRI	0	0	46,609	0	448,727	58.00
60.00	06000	LABORATORY	2,987	2,987	675,753	0	1,572,773	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	0	0	2,123	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	304,641	0	437,061	65.00
66.00	06600	PHYSICAL THERAPY	551	551	84,326	0	543,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	23,056	0	147,516	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,449	0	14,496	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	174,241	0	254,540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	331,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,749,499	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,544,695	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	56,250	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	79,822	0	116,217	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	238,292	0	373,747	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	185,716	0	325,823	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,246,466	0	1,953,079	88.02
91.00	09100	EMERGENCY	6,282	6,282	1,004,013	0	1,487,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,756	114,756	12,473,464	-8,361,446	27,579,592	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	5,375	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	4,029	0	42,492	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	49,411	0	307,563	194.01
194.02	07954	SENIOR CIRCLE	540	540	34,919	0	59,483	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	134,896	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	775,855	982,204	2,298,266		8,361,446	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.161394	7.800098	0.182956		0.297249	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,239		189,111	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000895		0.006723	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: 14-0294

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	87,053				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	140,634			8.00
9.00	00900	HOUSEKEEPING	4,150	0	82,351		9.00
10.00	01000	DIETARY	3,878	0	3,878	40,879	10.00
11.00	01100	CAFETERIA	0	0	0	14,306	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,732	46,411	22,732	37,326	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	8,437	4,803	3,004	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,444	28,128	15,444	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	8,437	4,345	0	54.00
54.01	03630	ULTRA SOUND	509	0	509	0	54.01
56.00	05600	RADIOISOTOPE	427	0	427	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	2,987	0	2,987	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	4,219	1,366	0	65.00
66.00	06600	PHYSICAL THERAPY	551	0	551	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
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	6,282	45,002	6,282	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,887	140,634	71,185	40,330	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	194.01
194.02	07954	SENIOR CIRCLE	540	0	540	0	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	194.03
194.04	07952	GUEST MEALS	0	0	0	549	194.04
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)	2,378,868	146,966	905,143	865,598	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.326663	1.045025	10.991281	21.174637	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	356,343	10,650	79,365	77,470	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.093403	0.075728	0.963741	1.895105	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: 14-0294

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,372,221				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,567,849			14.00
15.00	01500	PHARMACY	401,787	33,091	1,544,695		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,107	0	233,172,255	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,306,920	120,174	0	6,016,837	30.00
31.00	03100	INTENSIVE CARE UNIT	785,925	32,503	0	588,387	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,802,860	1,982,385	0	54,334,962	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	61,392	0	26,144,802	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,572	35,892	0	8,421,782	54.00
54.01	03630	ULTRA SOUND	48,465	8,131	0	2,614,278	54.01
56.00	05600	RADIOISOTOPE	15,820	2,428	0	1,316,962	56.00
57.00	05700	CT SCAN	142,793	31,620	0	31,452,407	57.00
58.00	05800	MRI	46,609	1,025	0	4,510,119	58.00
60.00	06000	LABORATORY	675,753	219,254	0	35,404,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	413,966	62.00
65.00	06500	RESPIRATORY THERAPY	304,641	21,715	0	3,032,561	65.00
66.00	06600	PHYSICAL THERAPY	0	3,984	0	3,573,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	137	0	976,898	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,777	68.00
69.00	06900	ELECTROCARDIOLOGY	174,241	720	0	4,548,748	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199,414	0	759,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,621,309	0	18,476,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,544,695	8,824,598	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	60,744	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	79,822	11,629	0	846,425	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	11,407	0	486,745	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,043	0	539,355	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	59,430	0	2,535,851	88.02
91.00	09100	EMERGENCY	1,004,013	76,948	0	17,188,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,372,221	4,553,738	1,544,695	233,172,255	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	7,575	0	0	194.01
194.02	07954	SENIOR CIRCLE	0	6,536	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	194.04
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)	1,484,197	642,870	936,962	238,614	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.201323	0.140738	0.606568	0.001023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,584	55,152	26,107	48,233	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004420	0.012074	0.016901	0.000207	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 10:31 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,847,499		4,847,499	0	4,847,499	30.00
31.00	03100	INTENSIVE CARE UNIT	1,098,900		1,098,900	0	1,098,900	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,230,016		9,230,016	0	9,230,016	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	125,980		125,980	0	125,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,866,417		1,866,417	0	1,866,417	54.00
54.01	03630	ULTRA SOUND	249,826		249,826	0	249,826	54.01
56.00	05600	RADIOISOTOPE	257,830		257,830	0	257,830	56.00
57.00	05700	CT SCAN	476,963		476,963	0	476,963	57.00
58.00	05800	MRI	597,971		597,971	0	597,971	58.00
60.00	06000	LABORATORY	2,387,757		2,387,757	0	2,387,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,002		9,002	0	9,002	62.00
65.00	06500	RESPIRATORY THERAPY	703,647	0	703,647	0	703,647	65.00
66.00	06600	PHYSICAL THERAPY	733,204	0	733,204	0	733,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,126	0	193,126	0	193,126	67.00
68.00	06800	SPEECH PATHOLOGY	18,981	0	18,981	0	18,981	68.00
69.00	06900	ELECTROCARDIOLOGY	380,630		380,630	0	380,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	459,291		459,291	0	459,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,516,618		2,516,618	0	2,516,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,949,844		2,949,844	0	2,949,844	73.00
74.00	07400	RENAL DIALYSIS	73,032		73,032	0	73,032	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	172,007		172,007	0	172,007	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	494,032		494,032	0	494,032	88.00
88.01	08801	RURAL HEALTH CLINIC II	430,685		430,685	0	430,685	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,581,693		2,581,693	0	2,581,693	88.02
91.00	09100	EMERGENCY	2,478,538		2,478,538	0	2,478,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	753,147		753,147	0	753,147	92.00
200.00		Subtotal (see instructions)	36,086,636	0	36,086,636	0	36,086,636	200.00
201.00		Less Observation Beds	753,147		753,147	0	753,147	201.00
202.00		Total (see instructions)	35,333,489	0	35,333,489	0	35,333,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 10:31 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				
9.00									
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,161,011		5,161,011			30.00	
31.00	03100	INTENSIVE CARE UNIT	588,387		588,387			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,682,241	41,652,721	54,334,962	0.169873	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	6,026,336	20,118,466	26,144,802	0.004819	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,037,530	6,384,252	8,421,782	0.221618	0.000000	54.00	
54.01	03630	ULTRA SOUND	151,892	2,462,386	2,614,278	0.095562	0.000000	54.01	
56.00	05600	RADIOISOTOPE	107,462	1,209,500	1,316,962	0.195776	0.000000	56.00	
57.00	05700	CT SCAN	4,792,233	26,660,174	31,452,407	0.015165	0.000000	57.00	
58.00	05800	MRI	70,038	4,440,081	4,510,119	0.132584	0.000000	58.00	
60.00	06000	LABORATORY	6,026,290	29,377,861	35,404,151	0.067443	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252,827	161,139	413,966	0.021746	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	1,734,926	1,297,635	3,032,561	0.232031	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	706,996	2,866,118	3,573,114	0.205200	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	249,043	727,855	976,898	0.197693	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	28,533	75,244	103,777	0.182902	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	960,244	3,588,504	4,548,748	0.083678	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	705,328	54,583	759,911	0.604401	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,581,163	7,895,506	18,476,669	0.136205	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,587,552	6,237,046	8,824,598	0.334275	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	60,744	0	60,744	1.202292	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	141	846,284	846,425	0.203216	0.000000	76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	486,745	486,745			88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	539,355	539,355			88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	2,535,851	2,535,851			88.02	
91.00	09100	EMERGENCY	2,179,244	15,008,962	17,188,206	0.144200	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	290,462	565,364	855,826	0.880024	0.000000	92.00	
200.00		Subtotal (see instructions)	57,980,623	175,191,632	233,172,255			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	57,980,623	175,191,632	233,172,255			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 10:31 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.169873			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.004819			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.221618			54.00
54.01	03630 ULTRA SOUND	0.095562			54.01
56.00	05600 RADIOISOTOPE	0.195776			56.00
57.00	05700 CT SCAN	0.015165			57.00
58.00	05800 MRI	0.132584			58.00
60.00	06000 LABORATORY	0.067443			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.021746			62.00
65.00	06500 RESPIRATORY THERAPY	0.232031			65.00
66.00	06600 PHYSICAL THERAPY	0.205200			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197693			67.00
68.00	06800 SPEECH PATHOLOGY	0.182902			68.00
69.00	06900 ELECTROCARDIOLOGY	0.083678			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.604401			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.136205			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.334275			73.00
74.00	07400 RENAL DIALYSIS	1.202292			74.00
76.00	03020 ACUPUNCTURE	0.000000			76.00
76.01	03610 SLEEP LAB	0.203216			76.01
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	0.144200			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.880024			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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		531,004	0	531,004	2,729	194.58	30.00
31.00	INTENSIVE CARE UNIT		105,889		105,889	154	687.59	31.00
200.00	Total (lines 30 through 199)		636,893		636,893	2,883		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		1,330	258,791				
31.00	INTENSIVE CARE UNIT		59	40,568				
200.00	Total (lines 30 through 199)		1,389	299,359	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description			Title XVIII		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	381,573	54,334,962	0.007023	5,789,248	40,658	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,842	26,144,802	0.000376	2,754,442	1,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,632	8,421,782	0.011474	650,667	7,466	54.00
54.01	03630	ULTRA SOUND	11,700	2,614,278	0.004475	108,377	485	54.01
56.00	05600	RADIOISOTOPE	9,734	1,316,962	0.007391	76,159	563	56.00
57.00	05700	CT SCAN	9,785	31,452,407	0.000311	2,627,021	817	57.00
58.00	05800	MRI	4,220	4,510,119	0.000936	55,375	52	58.00
60.00	06000	LABORATORY	81,106	35,404,151	0.002291	3,478,384	7,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,991	413,966	0.007225	147,393	1,065	62.00
65.00	06500	RESPIRATORY THERAPY	31,810	3,032,561	0.010489	783,105	8,214	65.00
66.00	06600	PHYSICAL THERAPY	15,010	3,573,114	0.004201	485,684	2,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,221	976,898	0.001250	166,865	209	67.00
68.00	06800	SPEECH PATHOLOGY	120	103,777	0.001156	17,043	20	68.00
69.00	06900	ELECTROCARDIOLOGY	3,643	4,548,748	0.000801	593,970	476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,796	759,911	0.006311	430,957	2,720	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,163	18,476,669	0.001903	6,265,915	11,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,319	8,824,598	0.004342	1,264,316	5,490	73.00
74.00	07400	RENAL DIALYSIS	391	60,744	0.006437	52,607	339	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	1,534	846,425	0.001812	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,002	486,745	0.006168	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,667	539,355	0.004945	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,682	2,535,851	0.006184	0	0	88.02
91.00	09100	EMERGENCY	142,866	17,188,206	0.008312	1,249,167	10,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,501	855,826	0.096399	168,112	16,206	92.00
200.00		Total (lines 50 through 199)	986,308	227,422,857		27,164,807	118,132	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0294		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 8/2/2021 10:31 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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	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	2,729	0.00	1,330			30.00	
31.00	03100	INTENSIVE CARE UNIT		0	154	0.00	59			31.00	
200.00		Total (lines 30 through 199)		0	2,883		1,389			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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0294

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 10:31 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
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
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
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: 14-0294		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 10:31 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	54,334,962	0.000000
51.00	05100	RECOVERY ROOM		0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY		0	0	0	26,144,802	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	8,421,782	0.000000
54.01	03630	ULTRA SOUND		0	0	0	2,614,278	0.000000
56.00	05600	RADIOISOTOPE		0	0	0	1,316,962	0.000000
57.00	05700	CT SCAN		0	0	0	31,452,407	0.000000
58.00	05800	MRI		0	0	0	4,510,119	0.000000
60.00	06000	LABORATORY		0	0	0	35,404,151	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	413,966	0.000000
65.00	06500	RESPIRATORY THERAPY		0	0	0	3,032,561	0.000000
66.00	06600	PHYSICAL THERAPY		0	0	0	3,573,114	0.000000
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	976,898	0.000000
68.00	06800	SPEECH PATHOLOGY		0	0	0	103,777	0.000000
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,548,748	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	759,911	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	18,476,669	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	8,824,598	0.000000
74.00	07400	RENAL DIALYSIS		0	0	0	60,744	0.000000
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000
76.01	03610	SLEEP LAB		0	0	0	846,425	0.000000
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		0	0	0	486,745	0.000000
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	539,355	0.000000
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	2,535,851	0.000000
91.00	09100	EMERGENCY		0	0	0	17,188,206	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	855,826	0.000000
200.00		Total (lines 50 through 199)		0	0	0	227,422,857	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0294		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 8/2/2021 10:31 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	5,789,248	0	11,309,095	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	2,754,442	0	5,133,013	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	650,667	0	2,197,424	0	54.00
54.01	03630	ULTRA SOUND		0.000000	108,377	0	905,502	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	76,159	0	495,235	0	56.00
57.00	05700	CT SCAN		0.000000	2,627,021	0	9,144,826	0	57.00
58.00	05800	MRI		0.000000	55,375	0	1,399,140	0	58.00
60.00	06000	LABORATORY		0.000000	3,478,384	0	3,644,261	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	147,393	0	105,324	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	783,105	0	532,670	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	485,684	0	31,573	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	166,865	0	4,048	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	17,043	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	593,970	0	1,566,343	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	430,957	0	54,583	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	6,265,915	0	2,565,468	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,264,316	0	1,198,598	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	52,607	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	0	0	187,549	0	76.01
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	1,249,167	0	4,004,628	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	168,112	0	207,882	0	92.00
200.00		Total (lines 50 through 199)			27,164,807	0	44,687,162	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 10:31 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	0.169873	11,309,095	0	0	1,921,110	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.004819	5,133,013	0	0	24,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221618	2,197,424	0	0	486,989	54.00
54.01	03630	ULTRA SOUND	0.095562	905,502	0	0	86,532	54.01
56.00	05600	RADIOISOTOPE	0.195776	495,235	0	0	96,955	56.00
57.00	05700	CT SCAN	0.015165	9,144,826	0	0	138,681	57.00
58.00	05800	MRI	0.132584	1,399,140	0	0	185,504	58.00
60.00	06000	LABORATORY	0.067443	3,644,261	0	0	245,780	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.021746	105,324	0	0	2,290	62.00
65.00	06500	RESPIRATORY THERAPY	0.232031	532,670	0	0	123,596	65.00
66.00	06600	PHYSICAL THERAPY	0.205200	31,573	0	0	6,479	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197693	4,048	0	0	800	67.00
68.00	06800	SPEECH PATHOLOGY	0.182902	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083678	1,566,343	0	0	131,068	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.604401	54,583	0	0	32,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136205	2,565,468	0	0	349,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334275	1,198,598	5,529	0	400,661	73.00
74.00	07400	RENAL DIALYSIS	1.202292	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.203216	187,549	0	0	38,113	76.01
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	0.144200	4,004,628	0	0	577,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.880024	207,882	0	0	182,941	92.00
200.00		Subtotal (see instructions)		44,687,162	5,529	0	5,032,122	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,687,162	5,529	0	5,032,122	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 10:31 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
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
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	1,848	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
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
200.00		Subtotal (see instructions)	1,848	0	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	1,848	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 10:31 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)	2,729	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,729	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,305	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)	1,330	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)	4,847,499	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)	4,847,499	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,847,499	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)	1,776.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,362,466	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)	2,362,466	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 10:31 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,098,900	154	7,135.71	59	421,007	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)					3,746,202	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,529,675	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)					299,359	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					118,132	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					417,491	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,112,184	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)					424	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,776.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					753,147	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0294

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 10:31 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	531,004	4,847,499	0.109542	753,147	82,501	90.00
91.00 Nursing School cost	0	4,847,499	0.000000	753,147	0	91.00
92.00 Allied health cost	0	4,847,499	0.000000	753,147	0	92.00
93.00 All other Medical Education	0	4,847,499	0.000000	753,147	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 10:31 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		2,999,128	30.00
31.00	03100	INTENSIVE CARE UNIT		226,129	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.169873	5,789,248	983,437 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.004819	2,754,442	13,274 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.221618	650,667	144,200 54.00
54.01	03630	ULTRA SOUND	0.095562	108,377	10,357 54.01
56.00	05600	RADIOISOTOPE	0.195776	76,159	14,910 56.00
57.00	05700	CT SCAN	0.015165	2,627,021	39,839 57.00
58.00	05800	MRI	0.132584	55,375	7,342 58.00
60.00	06000	LABORATORY	0.067443	3,478,384	234,593 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.021746	147,393	3,205 62.00
65.00	06500	RESPIRATORY THERAPY	0.232031	783,105	181,705 65.00
66.00	06600	PHYSICAL THERAPY	0.205200	485,684	99,662 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197693	166,865	32,988 67.00
68.00	06800	SPEECH PATHOLOGY	0.182902	17,043	3,117 68.00
69.00	06900	ELECTROCARDIOLOGY	0.083678	593,970	49,702 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.604401	430,957	260,471 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.136205	6,265,915	853,449 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334275	1,264,316	422,629 73.00
74.00	07400	RENAL DIALYSIS	1.202292	52,607	63,249 74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0 76.00
76.01	03610	SLEEP LAB	0.203216	0	0 76.01
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	0.144200	1,249,167	180,130 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.880024	168,112	147,943 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		27,164,807	3,746,202 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		27,164,807	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:31 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)		2,630,643	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,008,491	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)		187,889	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		183,840	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		45.84	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)		5.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)		11.18	31.00
32.00	Sum of lines 30 and 31		16.86	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.71	33.00
34.00	Disproportionate share adjustment (see instructions)		33,753	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:31 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
35.01	Factor 3 (see instructions)		0.000030823	0.000000000
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		257,393	174,222
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		192,693	43,914
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		236,607	
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		4,281,223	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		5,428,265	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		5,141,505	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		355,852	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,497,357	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,497,357	61.00
62.00	Deductibles billed to program beneficiaries		534,776	62.00
63.00	Coinurance billed to program beneficiaries		2,816	63.00
64.00	Allowable bad debts (see instructions)		203,922	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		132,549	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		152,891	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,092,314	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)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		2,268	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-4,236	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		9,424	70.93
70.94	HRR adjustment amount (see instructions)		-17,854	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 10:31 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)	0	0	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)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		15,318	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,066,598	71.00
71.01	Sequestration adjustment (see instructions)		33,440	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,208,612	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-175,454	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		589,938	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)		644,036	216,246
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		1.0030924411	1.0012776903
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		1,992	276
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9949	0.9956
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-3,285	-951
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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 10:31 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	2,630,643	0	2,630,643		2,630,643
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,008,491	0		1,008,491	1,008,491
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	187,889	0	187,889		187,889
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	183,840	0		183,840	183,840
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0371	0.0371	0.0371	0.0371	
11.00	Disproportionate share adjustment (see instructions)	34.00	33,753	0	24,399	9,354	33,753
11.01	Uncompensated care payments	36.00	236,607	0	192,693	43,914	236,607
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	4,281,223	0	3,035,624	1,245,599	4,281,223
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,428,265	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,141,505	0	3,895,906	1,245,599	5,141,505
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	355,852	0	266,403	89,449	355,852

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 10:31 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	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	4,162,309	1,335,048	5,497,357
		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	278,699	0	208,644	70,055	278,699
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	77,153	0	57,759	19,394	77,153
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	355,852	0	266,403	89,449	355,852
		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				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/2/2021 10:31 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	2,630,643	2,630,643		2,630,643	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,008,491		1,008,491	1,008,491	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	187,889	187,889		187,889	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	183,840		183,840	183,840	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0371	0.0371	0.0371		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	33,753	24,399	9,354	33,753	11.00
11.01	Uncompensated care payments	36.00	236,607	192,693	43,914	236,607	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	4,281,223	3,035,624	1,245,599	4,281,223	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,428,265	3,940,093	1,488,172	5,428,265	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,141,505	3,713,976	1,427,529	5,141,505	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	355,852	247,715	108,137	355,852	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,961,691	1,535,666	5,497,357	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/2/2021 10:31 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	278,699	204,208	74,491	278,699	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	77,153	43,507	33,646	77,153	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	355,852	247,715	108,137	355,852	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	9,424	8,135	1,289	9,424	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	2,268	1,992	276	2,268	30.01
31.00	HRR adjustment (see instructions)	70.94	-17,854	-13,417	-4,437	-17,854	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-4,236	-3,285	-951	-4,236	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	15,318	15,318	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 10:31 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,848	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,032,122	2.00
3.00	OPPS payments		3,523,448	3.00
4.00	Outlier payment (see instructions)		14,429	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)		1,848	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,529	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)		5,529	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)		5,529	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,681	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)		1,848	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)		3,537,877	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		41	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		674,650	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)		2,865,034	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)		2,865,034	30.00
31.00	Primary payer payments		77	31.00
32.00	Subtotal (line 30 minus line 31)		2,864,957	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)		196,013	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		127,408	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		111,572	36.00
37.00	Subtotal (see instructions)		2,992,365	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)		2,992,365	40.00
40.01	Sequestration adjustment (see instructions)		19,750	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		2,952,042	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)		20,573	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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/2/2021 10:31 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		5,107,282		2,844,649	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		101,330		107,393	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)		5,208,612		2,952,042	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		20,573	6.01
6.02	SETTLEMENT TO PROGRAM		175,454		0	6.02
7.00	Total Medicare program liability (see instructions)		5,033,158		2,972,615	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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
8/2/2021 10:31 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

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

Provider CCN: 14-0294

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

Worksheet G

Date/Time Prepared:
8/2/2021 10:31 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	-523,853	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	13,238,481	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,357,586	0	0	0	6.00
7.00 Inventory	1,753,875	0	0	0	7.00
8.00 Prepaid expenses	560,366	0	0	0	8.00
9.00 Other current assets	141,637	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	12,812,920	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,640,000	0	0	0	12.00
13.00 Land improvements	162,111	0	0	0	13.00
14.00 Accumulated depreciation	-6,948	0	0	0	14.00
15.00 Buildings	6,697,204	0	0	0	15.00
16.00 Accumulated depreciation	-95,639	0	0	0	16.00
17.00 Leasehold improvements	37,301	0	0	0	17.00
18.00 Accumulated depreciation	-6,471	0	0	0	18.00
19.00 Fixed equipment	185,874	0	0	0	19.00
20.00 Accumulated depreciation	-27,260	0	0	0	20.00
21.00 Automobiles and trucks	3,722	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	1,680,613	0	0	0	23.00
24.00 Accumulated depreciation	-219,600	0	0	0	24.00
25.00 Minor equipment depreciable	868,005	0	0	0	25.00
26.00 Accumulated depreciation	-90,640	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)	10,828,272	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	-8,380,099	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	-8,380,099	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	15,261,093	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	8,710,158	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,052,260	0	0	0	38.00
39.00 Payroll taxes payable	460,807	0	0	0	39.00
40.00 Notes and loans payable (short term)	822,918	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	2,072,474	0	0	0	43.00
44.00 Other current liabilities	630,342	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	13,748,959	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	829,102	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	28,333	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	857,435	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	14,606,394	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	654,699	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	654,699	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	15,261,093	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0294

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

Worksheet G-1

Date/Time Prepared:
8/2/2021 10:31 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		4,556,313		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,006,152				2.00
3.00	Total (sum of line 1 and line 2)		6,562,465		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,562,465		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ADJUSTMENT DUE TO BANKRUPTCY	5,907,766		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)		5,907,766		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		654,699		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	ADJUSTMENT DUE TO BANKRUPTCY		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: 14-0294

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/2/2021 10:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,161,011		5,161,011	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,161,011		5,161,011	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	588,387		588,387	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)	588,387		588,387	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,749,398		5,749,398	17.00
18.00	Ancillary services	49,651,991	155,645,583	205,297,574	18.00
19.00	Outpatient services	2,469,706	15,574,326	18,044,032	19.00
20.00	RURAL HEALTH CLINIC	0	1,511,298	1,511,298	20.00
20.01	RURAL HEALTH CLINIC II	0	539,355	539,355	20.01
20.02	RURAL HEALTH CLINIC III	0	1,511,298	1,511,298	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,871,095	174,781,860	232,652,955	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,156,447		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,156,447		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0294

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

Worksheet G-3

Date/Time Prepared:
8/2/2021 10:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	232,652,955	1.00
2.00	Less contractual allowances and discounts on patients' accounts	188,176,950	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,476,005	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,156,447	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-680,442	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,262	6.00
7.00	Income from investments	-78,488	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	67,068	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	40	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	204,432	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUES	449,554	24.00
24.50	COVID-19 PHE Funding	2,039,726	24.50
25.00	Total other income (sum of lines 6-24)	2,686,594	25.00
26.00	Total (line 5 plus line 25)	2,006,152	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,006,152	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 10:31 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		278,699	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		77,153	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)		6.72	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)		355,852	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: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8524

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 am

		RHC I		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	78,052	0	78,052	0	78,052
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	83,979	0	83,979	0	83,979
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	38,432	0	38,432	0	38,432
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	200,463	0	200,463	0	200,463
11.00 Physician Services Under Agreement	0	0	0	0	0
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	0	0	0	0
15.00 Medical Supplies	0	11,407	11,407	0	11,407
16.00 Transportation (Health Care Staff)	0	197	197	0	197
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	27	27	0	27
19.00 Other Health Care Costs	0	8,224	8,224	0	8,224
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	19,855	19,855	0	19,855
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	200,463	19,855	220,318	0	220,318
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	3,153	3,153	0	3,153
30.00 Administrative Costs	37,829	68,850	106,679	0	106,679
31.00 Total Facility Overhead (sum of lines 29 and 30)	37,829	72,003	109,832	0	109,832
32.00 Total facility costs (sum of lines 22, 28 and 31)	238,292	91,858	330,150	0	330,150

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8524

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	78,052		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	83,979		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	38,432		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	200,463		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	11,407		15.00
16.00	Transportation (Health Care Staff)	0	197		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	27		18.00
19.00	Other Health Care Costs	0	8,224		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,855		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	220,318		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	3,153		29.00
30.00	Administrative Costs	0	106,679		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	109,832		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	330,150		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8523

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 am

		RHC II		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	59,504	0	59,504	0	59,504 2.00
3.00	Nurse Practitioner	63,043	0	63,043	0	63,043 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	20,587	0	20,587	0	20,587 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)	143,134	0	143,134	0	143,134 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	14,630	14,630	0	14,630 15.00
16.00	Transportation (Health Care Staff)	0	514	514	0	514 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	8,506	8,506	0	8,506 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,650	23,650	0	23,650 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	143,134	23,650	166,784	0	166,784 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	0	0	0	0	0 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	5,864	5,864	0	5,864 29.00
30.00	Administrative Costs	42,582	76,615	119,197	0	119,197 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	42,582	82,479	125,061	0	125,061 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	185,716	106,129	291,845	0	291,845 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8523

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	59,504	2.00
3.00	Nurse Practitioner	0	63,043	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	20,587	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	143,134	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	14,630	15.00
16.00	Transportation (Health Care Staff)	0	514	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	8,506	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,650	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	166,784	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	5,864	29.00
30.00	Administrative Costs	0	119,197	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	125,061	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	291,845	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8605

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

Date/Time Prepared:

8/2/2021 10:31 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	408,270	0	408,270	0	408,270
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	440,892	0	440,892	0	440,892
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	200,221	0	200,221	0	200,221
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	1,049,383	0	1,049,383	0	1,049,383
11.00 Physician Services Under Agreement	0	0	0	0	0
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	0	0	0	0
15.00 Medical Supplies	0	59,430	59,430	0	59,430
16.00 Transportation (Health Care Staff)	0	1,029	1,029	0	1,029
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	140	140	0	140
19.00 Other Health Care Costs	0	42,843	42,843	0	42,843
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	103,442	103,442	0	103,442
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,049,383	103,442	1,152,825	0	1,152,825
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	16,424	16,424	0	16,424
30.00 Administrative Costs	197,083	358,699	555,782	0	555,782
31.00 Total Facility Overhead (sum of lines 29 and 30)	197,083	375,123	572,206	0	572,206
32.00 Total facility costs (sum of lines 22, 28 and 31)	1,246,466	478,565	1,725,031	0	1,725,031

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294

Period:

Worksheet M-1

Component CCN: 14-8605

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	408,270	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	440,892	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	200,221	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	1,049,383	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	59,430	15.00
16.00	Transportation (Health Care Staff)	0	1,029	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	140	18.00
19.00	Other Health Care Costs	0	42,843	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	103,442	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,152,825	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	16,424	29.00
30.00	Administrative Costs	0	555,782	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	572,206	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,725,031	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294

Period:

Worksheet M-2

Component CCN: 14-8524

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	0.26	412	1	0
2.00	Physician Assistant	0.00	0	1	0
3.00	Nurse Practitioner	0.64	1,323	1	1
4.00	Subtotal (sum of lines 1 through 3)	0.90	1,735	1	1,735
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.90	1,735		1,735
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)				220,318
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)				220,318
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)				109,832
15.00	Parent provider overhead allocated to facility (see instructions)				163,882
16.00	Total overhead (sum of lines 14 and 15)				273,714
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				273,714
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				273,714
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				494,032

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294

Period:

Worksheet M-2

Component CCN: 14-8523

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	0.00	0	1	0
2.00	Physician Assistant	0.94	3,036	1	1
3.00	Nurse Practitioner	0.00	0	1	0
4.00	Subtotal (sum of lines 1 through 3)	0.94	3,036	1	3,036
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.94	3,036		3,036
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)				166,784
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)				166,784
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)				125,061
15.00	Parent provider overhead allocated to facility (see instructions)				138,840
16.00	Total overhead (sum of lines 14 and 15)				263,901
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				263,901
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				263,901
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				430,685

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294

Period:

Worksheet M-2

Component CCN: 14-8605

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 10:31 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	1.36	2,146	0	0
2.00	Physician Assistant	0.00	0	0	0
3.00	Nurse Practitioner	3.36	6,893	0	0
4.00	Subtotal (sum of lines 1 through 3)	4.72	9,039	0	9,039
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.72	9,039		9,039
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)				1,152,825
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)				1,152,825
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)				572,206
15.00	Parent provider overhead allocated to facility (see instructions)				856,662
16.00	Total overhead (sum of lines 14 and 15)				1,428,868
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				1,428,868
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,428,868
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,581,693

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 10:31 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)			494,032	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			27,721	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			466,311	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,735	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)			1,735	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			268.77	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	84.70	86.31		8.00
9.00	Rate for Program covered visits (see instructions)	268.77	268.77		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	682		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	183,301		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	183,301		16.00
16.01	Total program charges (see instructions)(from contractor's records)		113,737		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		21,590		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,795		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.)		97,985		16.04
16.05	Total program cost (see instructions)	0	132,780		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,025		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		13,224		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		132,780		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,765		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		150,545		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)		150,545		26.00
26.01	Sequestration adjustment (see instructions)		994		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		43,699		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)		105,852		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		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8523		Date/Time Prepared: 8/2/2021 10:31 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)			430,685	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			37,539	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			393,146	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,036	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,036	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			129.49	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		129.49	129.49	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,454	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	188,278	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	188,278	16.00
16.01	Total program charges (see instructions)(from contractor's records)			261,311	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			42,414	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			30,560	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.)			101,239	16.04
16.05	Total program cost (see instructions)		0	131,799	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			31,169	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			37,202	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			131,799	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,410	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			159,209	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)			159,209	26.00
26.01	Sequestration adjustment (see instructions)			1,051	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			136,788	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)			21,370	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		CROSSROADS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0294	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3		
		Component CCN: 14-8605		Date/Time Prepared: 8/2/2021 10:31 am		
		Title XVIII	RHC III	Cost		
			1.00			
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,581,693	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			35,473	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,546,220	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,039	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)			9,039	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			281.69	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			281.69	281.69	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	3,554	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	1,001,126	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	1,001,126	16.00
16.01	Total program charges (see instructions)(from contractor's records)				707,757	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				74,209	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				104,969	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.)				673,373	16.04
16.05	Total program cost (see instructions)			0	778,342	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				54,441	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				115,691	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				778,342	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				24,783	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				803,125	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)				803,125	26.00
26.01	Sequestration adjustment (see instructions)				5,301	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				902,911	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)				-105,087	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: 14-0294 Component CCN: 14-8524	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 10:31 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)		200,463	200,463	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001116	0.004362	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		224	874	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,604	5,660	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,828	6,534	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		220,318	220,318	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		273,714	273,714	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.026453	0.029657	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,241	8,118	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		13,069	14,652	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		58	414	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		225.33	35.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		49	190	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,041	6,724	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)			27,721	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)			17,765	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 10:31 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)		143,134	143,134	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003063	0.007699	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		438	1,102	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,863	4,134	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		9,301	5,236	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		166,784	166,784	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		263,901	263,901	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.055767	0.031394	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		14,717	8,285	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		24,018	13,521	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		93	303	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		258.26	44.62	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		74	186	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		19,111	8,299	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)			37,539	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)			27,410	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0294 Component CCN: 14-8605	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 10:31 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)		1,049,383	1,049,383	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001116	0.004362	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,171	4,577	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,869	4,223	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		7,040	8,800	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,152,825	1,152,825	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,428,868	1,428,868	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006107	0.007633	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,726	10,907	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		15,766	19,707	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		61	309	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		258.46	63.78	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		49	190	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,665	12,118	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)			35,473	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)			24,783	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 10:31 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			43,699	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			43,699	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			105,852	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			149,551	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: 14-0294 Component CCN: 14-8523	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 10:31 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			136,788	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			136,788	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			21,370	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			158,158	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: 14-0294 Component CCN: 14-8605	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 10:31 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			520,911	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			11/19/2020	382,000	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)			382,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			902,911	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			105,087	6.02
7.00	Total Medicare program liability (see instructions)			797,824	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00