

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: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/14/2021 10:19 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/14/2021	Time: 10:19 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-55,031	297,751	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	-253,763	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		239,039		0	10.00
200.00	Total	0	-308,794	536,790	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: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 10:19 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: SOUTH ADAMS STREET			PO Box: 160				1.00	
2.00	City: CARTHAGE			State: IL		Zip Code: 62321-		County: HANCOCK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O
4.00	Subprovider - IPF								P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O
8.00	Swing Beds - NF								N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		BOWEN CLINIC	143456	99914		02/05/1999	N	O
16.00	Hospital-Based Health Clinic - FQHC								N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	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.					2	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 10:19 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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/14/2021 10:19 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/14/2021 10:19 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	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
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: 14-1305
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		1.00		
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
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.	Y	Y	Y
				Respiratory
				4.00
				N
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 10:19 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		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	153,749	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	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	H55770	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 10:19 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: UNITYPOINT HEALTH (IA HEALTH SYSTEM)		Contractor's Name: WPS		Contractor's Number: 05001				141.00		
142.00	Street: 1776 WEST LAKES PARKWAY SUITE 400		PO Box:						142.00		
143.00	City: WEST DES MOINES		State: IA		Zip Code:		50266-8239		143.00		
									1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00	
									1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00		
									1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00	
				Part A	Part B	Title V	Title XIX				
				1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)											
155.00	Hospital			N	N	N	N			155.00	
156.00	Subprovider - IPF			N	N	N	N			156.00	
157.00	Subprovider - IRF			N	N	N	N			157.00	
158.00	SUBPROVIDER									158.00	
159.00	SNF			N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00	
161.00	CMHC				N	N	N			161.00	
									1.00		
Multicampus											
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus				
		0	1.00	2.00	3.00	4.00	5.00				
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00	
									1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act											
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00	
						Beginning	Ending				
						1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00	
						1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/14/2021 10:19 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/13/2021	Y	04/13/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/14/2021 10:19 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		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		Y		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.		Y		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.		Y		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.	TERESA	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		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: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/14/2021 10:19 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	18	6,588	34,992.00	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)		18	6,588	34,992.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		18	6,588	34,992.00	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	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		18				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: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/14/2021 10:19 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)	906	158	1,458			1.00
2.00	HMO and other (see instructions)	113	0				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	797	0	891			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	26			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,703	158	2,375			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		114	240			13.00
14.00	Total (see instructions)	1,703	272	2,615	0.00	149.24	14.00
15.00	CAH visits	8,157	4,112	20,649			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			0	0.00	0.00	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	RHC (CONSOLIDATED)	5,224	8,043	27,316	0.00	51.71	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	200.95	27.00
28.00	Observation Bed Days		40	201			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	25	56			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: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/14/2021 10:19 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	215	73	440	1.00
2.00 HMO and other (see instructions)			27	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	215	73	440	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	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1305 Component CCN: 14-3456		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 7/14/2021 10:19 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			IL				2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
9.01								9.01	
9.02								9.02	
9.03								9.03	
9.04								9.04	
9.05								9.05	
9.06								9.06	
9.07								9.07	
9.08								9.08	
9.09								9.09	
9.10								9.10	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y		6		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number			BOWEN CLINIC		143456		14.00	
14.01				WOMEN & FAMILY MEDICAL GROUP CLINIC		143405		14.01	
14.02				LAHARPE CLINIC		148534		14.02	
14.03				NAUVOO CLINIC		148547		14.03	
14.04				CARTHAGE CLINIC		148571		14.04	
14.05				COLCHESTER CLINIC		148572		14.05	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1305
 Component CCN: 14-3456

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

 Worksheet S-8
 Date/Time Prepared:
 7/14/2021 10:19 am

		Y/N	V	XVIII	XIX	Total Visits	Cost
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)	1.00	2.00	3.00	4.00	5.00	15.00
		County					
2.00	City, State, ZIP Code, County	HANCOCK					2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
Facility hours of operations (1)							
11.00	CLINIC	08:00	16:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1305

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

Worksheet S-10

Date/Time Prepared:
7/14/2021 10:19 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)		0.512093	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,693,997	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		11,652,930	6.00
7.00	Medicaid cost (line 1 times line 6)		5,967,384	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)		1,273,387	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)		1,273,387	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	288,106	599,635	887,741
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	147,537	599,635	747,172
22.00	Payments received from patients for amounts previously written off as charity care	1,343	11,892	13,235
23.00	Cost of charity care (line 21 minus line 22)	146,194	587,743	733,937
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,637,672	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		241,300	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		371,230	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,266,442	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		778,466	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,512,403	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,785,790	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

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

Worksheet A

Date/Time Prepared:
7/14/2021 10:19 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	NEW CAP REL COSTS-BLDG & FIXT		1,256,964	1,256,964	-1,241,557	15,407	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	1,538,479	1,538,479	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	377,628	377,628	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		749,765	749,765	-20,340	729,425	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	42,026	42,026	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	168,389	3,220,225	3,388,614	-11,381	3,377,233	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,011,015	2,797,097	4,808,112	129,191	4,937,303	5.01
7.00	00700	OPERATION OF PLANT	220,339	507,722	728,061	0	728,061	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,475	88,475	0	88,475	8.00
9.00	00900	HOUSEKEEPING	172,992	36,947	209,939	0	209,939	9.00
10.00	01000	DIETARY	206,600	175,623	382,223	-160,288	221,935	10.00
11.00	01100	CAFETERIA	0	0	0	160,288	160,288	11.00
13.00	01300	NURSING ADMINISTRATION	179,726	56,998	236,724	-88,426	148,298	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,258	11,799	289,057	0	289,057	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	88,426	88,426	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	499,020	33,321	532,341	0	532,341	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,177,152	125,399	1,302,551	314,083	1,616,634	30.00
43.00	04300	NURSERY	0	0	0	248,751	248,751	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357,715	831,930	1,189,645	-60,540	1,129,105	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380,527	174,510	555,037	-478,857	76,180	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	649,461	448,033	1,097,494	0	1,097,494	54.00
56.00	05600	RADIOISOTOPE	0	158,331	158,331	0	158,331	56.00
60.00	06000	LABORATORY	664,627	1,371,173	2,035,800	0	2,035,800	60.00
60.02	06002	GEO PSYCH	132,931	61,108	194,039	0	194,039	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,374	50,374	0	50,374	62.00
65.00	06500	RESPIRATORY THERAPY	261,654	67,575	329,229	-62,229	267,000	65.00
66.00	06600	PHYSICAL THERAPY	0	141,702	141,702	0	141,702	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,376	2,376	62,229	64,605	69.00
69.01	06901	PULMONARY REHAB	48,891	5,470	54,361	0	54,361	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,272	60,761	70,033	0	70,033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	157,204	157,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,178	1,315,143	1,509,321	133,070	1,642,391	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,575,668	1,133,999	5,709,667	-201,979	5,507,688	88.00
90.00	09000	CLINIC	183,683	709,362	893,045	-49,831	843,214	90.00
91.00	09100	EMERGENCY	472,257	1,984,609	2,456,866	0	2,456,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	74,855	5,394	80,249	0	80,249	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		794,063	794,063	-794,063	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,918,210	18,376,248	31,294,458	81,884	31,376,342	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	594,900	141,681	736,581	-81,884	654,697	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	2,017	17,487	19,504	0	19,504	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,515,127	18,535,416	32,050,543	0	32,050,543	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1305

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

Worksheet A

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	15,407	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-27,424	1,511,055	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-29,637	347,991	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	729,425	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	42,026	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-29,921	3,347,312	4.00
5.01	00550	ADMINISTRATION & GENERAL	-298,999	4,638,304	5.01
7.00	00700	OPERATION OF PLANT	0	728,061	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,475	8.00
9.00	00900	HOUSEKEEPING	0	209,939	9.00
10.00	01000	DIETARY	-1,093	220,842	10.00
11.00	01100	CAFETERIA	-52,838	107,450	11.00
13.00	01300	NURSING ADMINISTRATION	0	148,298	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,476	286,581	16.00
17.00	01700	SOCIAL SERVICE	0	88,426	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	532,341	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-81,142	1,535,492	30.00
43.00	04300	NURSERY	0	248,751	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-298,766	830,339	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	76,180	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,097,494	54.00
56.00	05600	RADIOISOTOPE	0	158,331	56.00
60.00	06000	LABORATORY	0	2,035,800	60.00
60.02	06002	GEO PSYCH	-44,443	149,596	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,374	62.00
65.00	06500	RESPIRATORY THERAPY	0	267,000	65.00
66.00	06600	PHYSICAL THERAPY	-12,357	129,345	66.00
69.00	06900	ELECTROCARDIOLOGY	0	64,605	69.00
69.01	06901	PULMONARY REHAB	0	54,361	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,033	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	157,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-526,013	1,116,378	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-49,650	5,458,038	88.00
90.00	09000	CLINIC	-599,605	243,609	90.00
91.00	09100	EMERGENCY	-271,421	2,185,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	80,249	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,325,785	29,050,557	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	654,697	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	19,504	194.01
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,325,785	29,724,758	200.00

RECLASSIFICATIONS

Provider CCN: 14-1305

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

Worksheet A-6

Date/Time Prepared:
7/14/2021 10:19 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	925,557		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	269,430		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	45,560		3.00
	TOTALS		0	1,240,547		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	86,639	73,649		1.00
	TOTALS		86,639	73,649		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	4,960		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	4,960		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	88,426	0		1.00
	TOTALS		88,426	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	612,922		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	108,198		2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	25,636		3.00
4.00	ADMINISTRATION & GENERAL	5.01	0	47,307		4.00
	TOTALS		0	794,063		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	163,513	66,593		1.00
2.00	NURSERY	43.00	176,762	71,989		2.00
	TOTALS		340,275	138,582		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	42,026		1.00
	TOTALS		0	42,026		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	50,977	11,252		1.00
	TOTALS		50,977	11,252		
	I - TO RECLASS NON RHC TIME					
1.00	OPERATING ROOM	50.00	93,401	0		1.00
2.00	CLINIC	90.00	77,956	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	81,142	0		3.00
	TOTALS		252,499	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	CLINIC	90.00	0	5,283		1.00
2.00	OPERATING ROOM	50.00	0	3,263		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,835		3.00
	TOTALS		0	11,381		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	157,204		1.00
	TOTALS		0	157,204		
	N - DERMATOLOGY DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	133,070		1.00
	TOTALS		0	133,070		
	O - CARE COORDINATION TIME					
1.00	ADMINISTRATION & GENERAL	5.01	0	81,884		1.00
	TOTALS		0	81,884		
500.00	Grand Total: Increases		818,816	2,688,618		500.00

RECLASSIFICATIONS

Provider CCN: 14-1305

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

Worksheet A-6

Date/Time Prepared:
7/14/2021 10:19 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,240,547	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
	TOTALS		0	1,240,547		
	B - TO RECLASS CAFETERIA					
1.00	DIETARY	10.00	86,639	73,649	0	1.00
	TOTALS		86,639	73,649		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,010	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,950	11	2.00
	TOTALS		0	4,960		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	NURSING ADMINISTRATION	13.00	88,426	0	0	1.00
	TOTALS		88,426	0		
	E - TO RECLASS INTEREST					
1.00	INTEREST EXPENSE	113.00	0	794,063	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	794,063		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	163,513	66,593	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	176,762	71,989	0	2.00
	TOTALS		340,275	138,582		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	42,026	9	1.00
	TOTALS		0	42,026		
	H - TO RECLASS EKG TIME					
1.00	RESPIRATORY THERAPY	65.00	50,977	11,252	0	1.00
	TOTALS		50,977	11,252		
	I - TO RECLASS NON RHC TIME					
1.00	RURAL HEALTH CLINIC	88.00	252,499	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		252,499	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,381	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	11,381		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	OPERATING ROOM	50.00	0	157,204	0	1.00
	TOTALS		0	157,204		
	N - DERMATOLOGY DRUGS RECLASS					
1.00	CLINIC	90.00	0	133,070	0	1.00
	TOTALS		0	133,070		
	O - CARE COORDINATION TIME					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	81,884	0	1.00
	TOTALS		0	81,884		
500.00	Grand Total: Decreases		818,816	2,688,618		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/14/2021 10:19 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	499,957	0	0	0	0	1.00	
2.00	Land Improvements	1,330,154	98,960	0	98,960	31,167	2.00	
3.00	Buildings and Fixtures	25,077,868	187,321	0	187,321	30,664	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	8,098,389	485,733	0	485,733	114,474	6.00	
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	36,975,137	772,014	0	772,014	176,305	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	36,975,137	772,014	0	772,014	176,305	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	499,957	0				1.00	
2.00	Land Improvements	1,397,947	0				2.00	
3.00	Buildings and Fixtures	25,234,525	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,469,648	0				6.00	
7.00	HIT designated Assets	1,968,769	0				7.00	
8.00	Subtotal (sum of lines 1-7)	37,570,846	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	37,570,846	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,256,964	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	749,765	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,006,729	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,256,964				1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0				1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	749,765				2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,006,729				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/14/2021 10:19 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	NEW CAP REL COSTS-BLDG & FIXT	1,809,283	0	1,809,283	0.048157	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	19,895,299	0	19,895,299	0.529540	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,427,847	0	5,427,847	0.144470	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9,937,687	0	9,937,687	0.264505	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	500,730	0	500,730	0.013328	0	2.01
3.00	Total (sum of lines 1-2)	37,570,846	0	37,570,846	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,407	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	908,011	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	269,430	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	707,739	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	42,026	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,942,613	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	15,407	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	603,044	0	0	0	1,511,055	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	78,561	0	0	0	347,991	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,686	0	0	0	729,425	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	42,026	2.01
3.00	Total (sum of lines 1-2)	703,291	0	0	0	2,645,904	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

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

Worksheet A-8

Date/Time Prepared:
7/14/2021 10:19 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	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)			0 CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-17,546	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	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	-1,601	ADMINISTRATION & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,325,298			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	559,253			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,838	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	-2,476	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,093	DIETARY	10.00	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	0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-12,357	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B			0 NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB			0 CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1305

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

Worksheet A-8

Date/Time Prepared:
7/14/2021 10:19 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	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP			0 CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-6,577	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A		0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.00
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	34.00
35.00	IT MISC REVENUE	B		0 ADMINISTRATION & GENERAL	5.01	0	35.00
36.00	LOBBYING	A	-8,210	0 ADMINISTRATION & GENERAL	5.01	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	37.00
38.00	ADVERTISING - LAHARPE	A		0 RURAL HEALTH CLINIC	88.00	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-97,031	0 ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTISING- RHC	A	-18,502	0 RURAL HEALTH CLINIC	88.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	41.00
42.00	ADVERTISING - WOMENS & FAMILY RHC	A		0 RURAL HEALTH CLINIC	88.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-22,944	0 RURAL HEALTH CLINIC	88.00	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-9,878	0 NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-6,054	0 RURAL HEALTH CLINIC	88.00	0	45.00
45.01	AMORT OF BOND COSTS	A		0 CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.01
45.02	RENTAL INCOME - MIDWEST	B		0 CLINIC	90.00	0	45.02
45.03	PROVIDER TAX	A	-623,931	0 ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-6,972	0 ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-29,637	0 CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06	PHYSICIAN RECRUITMENT	A	-110	0 ADMINISTRATION & GENERAL	5.01	0	45.06
45.07	ADVERTISING - NAUVOO	A		0 RURAL HEALTH CLINIC	88.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-25,034	0 ADMINISTRATION & GENERAL	5.01	0	45.08
45.09	RADIOLOGY	B		0 RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	MARKETING SALARIES	A	-76,152	0 ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-19,211	0 ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTHAGE INTEREST	A		0 ADMINISTRATION & GENERAL	5.01	0	45.12
45.13	ADVERTISING - COLCHSTR	A		0 RURAL HEALTH CLINIC	88.00	0	45.13
45.14	340B PHARMACY	A	-526,013	0 DRUGS CHARGED TO PATIENTS	73.00	0	45.14
45.15	GEROPSYCH	B		0 DIETARY	10.00	0	45.15
45.16	LAHARPE CONSULTANT FEE-MISC REV	B	-1,900	0 RURAL HEALTH CLINIC	88.00	0	45.16
45.17	STAFF SERVICES RHC	B	-250	0 RURAL HEALTH CLINIC	88.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,332,362				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: 14-1305

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

Worksheet A-8-1

Date/Time Prepared:
7/14/2021 10:19 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.01	ADMINISTRATION & GENERAL	MANAGEMENT FEES	0	12,000	1.00
2.00	5.01	ADMINISTRATION & GENERAL	PURCHASED SERVICES	0	305,730	2.00
3.00	5.01	ADMINISTRATION & GENERAL	HOME OFFICE ALLOCATION	924,290	0	3.00
4.00	5.01	ADMINISTRATION & GENERAL	RELATED PARTY INTEREST	0	47,307	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			924,290	365,037	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	UNITYPOINT HEAL	100.00	UNITYPOINT HEAL	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: 14-1305

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

Worksheet A-8-1

Date/Time Prepared:
7/14/2021 10:19 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	-12,000	0		1.00
2.00	-305,730	0		2.00
3.00	924,290	0		3.00
4.00	-47,307	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	559,253			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	HEALTH SYSTEM		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: 14-1305

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

Worksheet A-8-2

Date/Time Prepared:
7/14/2021 10:19 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	60.00	LABORATORY	50,000	0	50,000	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	81,142	81,142	0	0	0	2.00
3.00	60.02	GEO PSYCH	44,443	44,443	0	0	0	3.00
4.00	50.00	OPERATING ROOM	298,766	298,766	0	0	0	4.00
5.00	90.00	CLINIC	599,605	599,605	0	0	0	5.00
6.00	91.00	EMERGENCY	1,896,783	271,421	1,625,362	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	29,921	29,921	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,000,660	1,325,298	1,675,362		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	81,142		2.00
3.00	60.02	GEO PSYCH	0	0	0	44,443		3.00
4.00	50.00	OPERATING ROOM	0	0	0	298,766		4.00
5.00	90.00	CLINIC	0	0	0	599,605		5.00
6.00	91.00	EMERGENCY	0	0	0	271,421		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	29,921		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,325,298		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.75	7.00
8.00	Optional travel expense rate per mile					0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	310.25	637.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.69	65.02	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.35	43.35	32.51			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					26,896	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					41,467	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					68,363	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					68,363	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					68,363	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am	
				Physical Therapy		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.69	65.02	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					68,363	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					68,363	63.00
64.00	Total cost of outside supplier services (from your records)					80,720	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					12,357	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.75	7.00
8.00	Optional travel expense rate per mile					0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	194.50	501.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.16	61.62	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.08	41.08	30.81			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					15,980	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					30,872	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					46,852	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					46,852	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.36	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,541	22.00
23.00	Total salary equivalency (see instructions)					52,541	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.16	61.62	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
							1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						52,541
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0
60.00	Overtime allowance (from column 5, line 56)						0
61.00	Equipment cost (see instructions)						0
62.00	Supplies (see instructions)						0
63.00	Total allowance (sum of lines 57-62)						52,541
64.00	Total cost of outside supplier services (from your records)						59,118
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						6,577
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0
100.02	Line 33 = line 28 = sum of lines 26 and 27						0
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						0
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0
102.02	Line 35 = sum of lines 31 and 32						0

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.75	7.00
8.00	Optional travel expense rate per mile						0.58	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	20.25	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	78.95	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.48	39.48	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						1,599	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						1,599	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						1,599	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						78.96	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						61,589	22.00
23.00	Total salary equivalency (see instructions)						61,589	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/14/2021 10:19 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.95	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						61,589	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						61,589	63.00
64.00	Total cost of outside supplier services (from your records)						1,864	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB		NEW MVBLE EQUIP
			0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	15,407	15,407				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,511,055	0	1,511,055			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	347,991	0	0	347,991		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	729,425				729,425	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	42,026				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,347,312	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	4,638,304	5,423	414,645	138,570	209,088	5.01
7.00	00700	OPERATION OF PLANT	728,061	674	71,518	0	34,110	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,113	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	88,475	0	6,192	0	2,517	8.00
9.00	00900	HOUSEKEEPING	209,939		15,515	2,798	6,307	9.00
10.00	01000	DIETARY	220,842	0	29,328	0	11,923	10.00
11.00	01100	CAFETERIA	107,450	0	16,706	0	6,792	11.00
13.00	01300	NURSING ADMINISTRATION	148,298	0	9,016	0	3,666	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	286,581	1,661	26,777		23,293	16.00
17.00	01700	SOCIAL SERVICE	88,426	0	5,954	0	2,421	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	532,341	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,535,492	0	332,819	0	135,306	30.00
43.00	04300	NURSERY	248,751	0	7,655	0	3,112	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	830,339	0	136,332	0	55,425	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,180	0	30,145	0	12,255	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,097,494	0	150,690	0	61,263	54.00
56.00	05600	RADIOISOTOPE	158,331	0	10,547	0	4,288	56.00
60.00	06000	LABORATORY	2,035,800	0	57,432		23,349	60.00
60.02	06002	GEO PSYCH	149,596	0	0	13,530	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,374	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	267,000	0	23,510	0	9,558	65.00
66.00	06600	PHYSICAL THERAPY	129,345	0	8,812	0	3,583	66.00
69.00	06900	ELECTROCARDIOLOGY	64,605	0	38,277	0	15,561	69.00
69.01	06901	PULMONARY REHAB	54,361	0	0	13,377	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,033	0	11,092	0	4,509	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	157,204	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,116,378	0	42,563	0	17,304	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,458,038	7,649	0	92,774	57,154	88.00
90.00	09000	CLINIC	243,609	0	0	7,433	0	90.00
91.00	09100	EMERGENCY	2,185,445	0	63,012	0	25,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	80,249	0	0	9,131	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,050,557	15,407	1,508,537	284,726	728,401	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,518	0	1,024	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	654,697	0	0	63,265	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	19,504	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
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)	29,724,758	15,407	1,511,055	347,991	729,425	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	4.00	4A	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	42,026					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,347,312				4.00
5.01	00550	ADMINISTRATION & GENERAL	16,735	504,355	5,927,120	5,927,120		5.01
7.00	00700	OPERATION OF PLANT	0	55,260	889,623	221,572	1,111,195	7.00
7.01	00701	OPERATION OF PLANT MOB	859	0	7,972	1,986	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	97,184	24,205	6,714	8.00
9.00	00900	HOUSEKEEPING	338	43,386	278,283	69,310	16,821	9.00
10.00	01000	DIETARY	0	30,086	292,179	72,771	31,798	10.00
11.00	01100	CAFETERIA	0	21,729	152,677	38,026	18,112	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,898	183,878	45,797	9,775	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,535	407,847	101,580	29,031	16.00
17.00	01700	SOCIAL SERVICE	0	22,177	118,978	29,633	6,456	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	125,152	657,493	163,757	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	356,584	2,360,201	587,839	360,843	30.00
43.00	04300	NURSEY	0	44,331	303,849	75,678	8,300	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	113,138	1,135,234	282,745	147,813	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,095	128,675	32,048	32,683	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,882	1,472,329	366,703	163,380	54.00
56.00	05600	RADIOISOTOPE	0	0	173,166	43,129	11,435	56.00
60.00	06000	LABORATORY	0	166,686	2,283,267	568,677	62,268	60.00
60.02	06002	GEO PSYCH	1,634	33,339	198,099	49,339	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	50,374	12,546	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	52,837	352,905	87,896	25,490	65.00
66.00	06600	PHYSICAL THERAPY	0	0	141,740	35,302	9,554	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,785	131,228	32,684	41,500	69.00
69.01	06901	PULMONARY REHAB	1,615	12,262	81,615	20,327	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,325	87,959	21,907	12,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	157,204	39,154	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,699	1,224,944	305,088	46,148	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,204	1,084,235	6,711,054	1,671,483	0	88.00
90.00	09000	CLINIC	898	65,618	317,558	79,092	0	90.00
91.00	09100	EMERGENCY	0	118,440	2,392,514	595,887	68,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	1,103	18,773	109,256	27,212	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,386	3,197,607	28,826,405	5,703,373	1,108,465	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,542	882	2,730	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,640	149,199	874,801	217,881	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	506	20,010	4,984	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,026	3,347,312	29,724,758	5,927,120	1,111,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	9,958					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	128,103				8.00
9.00	00900	HOUSEKEEPING	138	0	364,552			9.00
10.00	01000	DIETARY	0	0	6,433	403,181		10.00
11.00	01100	CAFETERIA	0	0	3,664	0	212,479	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,978	0	5,889	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,568	0	14,540	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,306	0	4,672	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,043	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	53,137	73,004	403,181	42,307	30.00
43.00	04300	NURSERY	0	0	1,679	0	5,843	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	38,654	29,905	0	12,823	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,612	0	1,231	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,212	33,054	0	20,224	54.00
56.00	05600	RADIOISOTOPE	0	0	2,314	0	0	56.00
60.00	06000	LABORATORY	0	0	12,598	0	26,493	60.00
60.02	06002	GEO PSYCH	666	0	7,254	0	5,378	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,157	0	7,380	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,933	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,396	0	1,785	69.00
69.01	06901	PULMONARY REHAB	658	0	7,172	0	2,064	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,433	0	404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,336	0	4,586	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,567	8,274	80,581	0	38,758	88.00
90.00	09000	CLINIC	366	215	3,985	0	0	90.00
91.00	09100	EMERGENCY	0	13,611	13,822	0	13,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	449	0	4,896	0	2,353	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,844	128,103	330,080	403,181	212,479	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	552	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,114	0	33,920	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,958	128,103	364,552	403,181	212,479	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	247,317					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	565,566				16.00
17.00	01700	SOCIAL SERVICE	0	0	161,045			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,372	0	0	828,665		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111,242	39,570	157,824	0	4,189,148	30.00
43.00	04300	NURSERY	15,365	2,192	0	0	412,906	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,717	41,040	0	0	1,721,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,237	3,751	0	0	208,237	52.00
53.00	05300	ANESTHESIOLOGY	0	20,245	0	828,665	848,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	111,789	0	0	2,181,691	54.00
56.00	05600	RADIOISOTOPE	0	3,809	0	0	233,853	56.00
60.00	06000	LABORATORY	0	145,070	0	0	3,098,373	60.00
60.02	06002	GEO PSYCH	0	2,799	0	0	263,535	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	768	0	0	63,688	62.00
65.00	06500	RESPIRATORY THERAPY	19,406	9,322	0	0	507,556	65.00
66.00	06600	PHYSICAL THERAPY	0	3,311	0	0	191,840	66.00
69.00	06900	ELECTROCARDIOLOGY	4,693	6,511	0	0	226,797	69.00
69.01	06901	PULMONARY REHAB	0	2,652	0	0	114,488	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,993	0	0	137,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,079	0	0	200,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,059	38,753	0	0	1,640,914	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	83,851	0	0	8,598,568	88.00
90.00	09000	CLINIC	0	2,149	0	0	403,365	90.00
91.00	09100	EMERGENCY	36,040	30,456	3,221	0	3,167,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6,186	456	0	0	150,808	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	247,317	565,566	161,045	828,665	28,562,342	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	7,706	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,129,716	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	24,994	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	247,317	565,566	161,045	828,665	29,724,758	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,189,148	30.00
43.00	04300	NURSERY	0	412,906	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,721,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	208,237	52.00
53.00	05300	ANESTHESIOLOGY	0	848,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,181,691	54.00
56.00	05600	RADIOISOTOPE	0	233,853	56.00
60.00	06000	LABORATORY	0	3,098,373	60.00
60.02	06002	GEO PSYCH	0	263,535	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	63,688	62.00
65.00	06500	RESPIRATORY THERAPY	0	507,556	65.00
66.00	06600	PHYSICAL THERAPY	0	191,840	66.00
69.00	06900	ELECTROCARDIOLOGY	0	226,797	69.00
69.01	06901	PULMONARY REHAB	0	114,488	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	137,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	200,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,640,914	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	8,598,568	88.00
90.00	09000	CLINIC	0	403,365	90.00
91.00	09100	EMERGENCY	0	3,167,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	150,808	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	28,562,342	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,706	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,129,716	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	24,994	194.01
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	29,724,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	5,423	414,645	138,570	209,088	5.01
7.00	00700	OPERATION OF PLANT	0	674	71,518	0	34,110	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,113	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	6,192	0	2,517	8.00
9.00	00900	HOUSEKEEPING	0	0	15,515	2,798	6,307	9.00
10.00	01000	DIETARY	0	0	29,328	0	11,923	10.00
11.00	01100	CAFETERIA	0	0	16,706	0	6,792	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	9,016	0	3,666	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,661	26,777	0	23,293	16.00
17.00	01700	SOCIAL SERVICE	0	0	5,954	0	2,421	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	332,819	0	135,306	30.00
43.00	04300	NURSERY	0	0	7,655	0	3,112	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	136,332	0	55,425	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	30,145	0	12,255	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	150,690	0	61,263	54.00
56.00	05600	RADIOISOTOPE	0	0	10,547	0	4,288	56.00
60.00	06000	LABORATORY	0	0	57,432	0	23,349	60.00
60.02	06002	GEO PSYCH	0	0	0	13,530	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	23,510	0	9,558	65.00
66.00	06600	PHYSICAL THERAPY	0	0	8,812	0	3,583	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	38,277	0	15,561	69.00
69.01	06901	PULMONARY REHAB	0	0	0	13,377	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11,092	0	4,509	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	42,563	0	17,304	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,649	0	92,774	57,154	88.00
90.00	09000	CLINIC	0	0	0	7,433	0	90.00
91.00	09100	EMERGENCY	0	0	63,012	0	25,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	9,131	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,407	1,508,537	284,726	728,401	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,518	0	1,024	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	63,265	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,407	1,511,055	347,991	729,425	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
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Cost Center Description			CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			MOB MVBLE EQUIP					
			2.01	2A	4.00	5.01	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	16,735	784,461	0	784,461		5.01
7.00	00700	OPERATION OF PLANT	0	106,302	0	29,326	135,628	7.00
7.01	00701	OPERATION OF PLANT MOB	859	7,972	0	263	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,709	0	3,204	819	8.00
9.00	00900	HOUSEKEEPING	338	24,958	0	9,173	2,053	9.00
10.00	01000	DIETARY	0	41,251	0	9,631	3,881	10.00
11.00	01100	CAFETERIA	0	23,498	0	5,033	2,211	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,682	0	6,061	1,193	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,731	0	13,444	3,543	16.00
17.00	01700	SOCIAL SERVICE	0	8,375	0	3,922	788	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	21,674	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	468,125	0	77,802	44,045	30.00
43.00	04300	NURSERY	0	10,767	0	10,016	1,013	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	191,757	0	37,422	18,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,400	0	4,242	3,989	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	211,953	0	48,534	19,941	54.00
56.00	05600	RADIOISOTOPE	0	14,835	0	5,708	1,396	56.00
60.00	06000	LABORATORY	0	80,781	0	75,266	7,600	60.00
60.02	06002	GEO PSYCH	1,634	15,164	0	6,530	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,661	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	33,068	0	11,633	3,111	65.00
66.00	06600	PHYSICAL THERAPY	0	12,395	0	4,672	1,166	66.00
69.00	06900	ELECTROCARDIOLOGY	0	53,838	0	4,326	5,065	69.00
69.01	06901	PULMONARY REHAB	1,615	14,992	0	2,690	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,601	0	2,899	1,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,182	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,867	0	40,379	5,633	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,204	168,781	0	221,217	0	88.00
90.00	09000	CLINIC	898	8,331	0	10,468	0	90.00
91.00	09100	EMERGENCY	0	88,629	0	78,867	8,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	1,103	10,234	0	3,602	0	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,386	2,571,457	0	754,847	135,295	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,542	0	117	333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,640	70,905	0	28,837	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	660	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,026	2,645,904	0	784,461	135,628	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	8,235					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,732				8.00
9.00	00900	HOUSEKEEPING	114	0	36,298			9.00
10.00	01000	DIETARY	0	0	641	55,404		10.00
11.00	01100	CAFETERIA	0	0	365	0	31,107	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	197	0	862	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,251	0	2,129	16.00
17.00	01700	SOCIAL SERVICE	0	0	130	0	684	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	299	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,281	7,269	55,404	6,196	30.00
43.00	04300	NURSERY	0	0	167	0	855	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,842	2,978	0	1,877	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	658	0	180	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,413	3,291	0	2,961	54.00
56.00	05600	RADIOISOTOPE	0	0	230	0	0	56.00
60.00	06000	LABORATORY	0	0	1,254	0	3,879	60.00
60.02	06002	GEO PSYCH	551	0	722	0	787	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	513	0	1,080	65.00
66.00	06600	PHYSICAL THERAPY	0	0	192	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	836	0	261	69.00
69.01	06901	PULMONARY REHAB	545	0	714	0	302	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	242	0	59	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	930	0	671	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,775	822	8,026	0	5,674	88.00
90.00	09000	CLINIC	303	21	397	0	0	90.00
91.00	09100	EMERGENCY	0	1,353	1,376	0	2,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	372	0	487	0	344	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,660	12,732	32,866	55,404	31,107	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	55	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,575	0	3,377	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,235	12,732	36,298	55,404	31,107	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	20,995					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,098				16.00
17.00	01700	SOCIAL SERVICE	0	0	13,899			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	456	0	0	22,429		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,445	5,046	13,621		692,234	30.00
43.00	04300	NURSERY	1,304	279	0		24,401	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,862	5,233	0		264,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	275	478	0		52,222	52.00
53.00	05300	ANESTHESIOLOGY	0	2,582	0		2,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,255	0		302,348	54.00
56.00	05600	RADIOISOTOPE	0	486	0		22,655	56.00
60.00	06000	LABORATORY	0	18,478	0		187,258	60.00
60.02	06002	GEO PSYCH	0	357	0		24,111	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	98	0		1,759	62.00
65.00	06500	RESPIRATORY THERAPY	1,647	1,189	0		52,241	65.00
66.00	06600	PHYSICAL THERAPY	0	422	0		18,847	66.00
69.00	06900	ELECTROCARDIOLOGY	398	830	0		65,554	69.00
69.01	06901	PULMONARY REHAB	0	338	0		19,581	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,657	0		21,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	520	0		5,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,024	4,942	0		113,446	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,692	0		418,987	88.00
90.00	09000	CLINIC	0	274	0		19,794	90.00
91.00	09100	EMERGENCY	3,059	3,884	278		187,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	525	58	0		15,622	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,995	72,098	13,899	0	2,513,074	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		4,047	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		105,694	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.01	07952	FITNESS CENTER	0	0	0		660	194.01
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				22,429	22,429	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,995	72,098	13,899	22,429	2,645,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	692,234	30.00
43.00	04300	NURSERY	0	24,401	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	264,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,222	52.00
53.00	05300	ANESTHESIOLOGY	0	2,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	302,348	54.00
56.00	05600	RADIOISOTOPE	0	22,655	56.00
60.00	06000	LABORATORY	0	187,258	60.00
60.02	06002	GEO PSYCH	0	24,111	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,759	62.00
65.00	06500	RESPIRATORY THERAPY	0	52,241	65.00
66.00	06600	PHYSICAL THERAPY	0	18,847	66.00
69.00	06900	ELECTROCARDIOLOGY	0	65,554	69.00
69.01	06901	PULMONARY REHAB	0	19,581	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	113,446	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	418,987	88.00
90.00	09000	CLINIC	0	19,794	90.00
91.00	09100	EMERGENCY	0	187,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	15,622	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,513,074	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,047	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	105,694	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	194.00
194.01	07952	FITNESS CENTER	0	660	194.01
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		Cross Foot Adjustments	0	22,429	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,645,904	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

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

Worksheet B-1

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADM IN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	44,412				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				52,734		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	12,187	9,955	15,116	9,955	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	1,251	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,132	0	6,665	4,132	6,665	88.00
90.00	09000	CLINIC	0	0	534	0	534	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,322	44,338	20,455	52,660	20,455	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,545	0	4,545	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	15,407	1,511,055	347,991	729,425	42,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.851358	34.023575	13.919640	13.832158	1.681040	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1305

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

Worksheet B-1

Date/Time Prepared:

7/14/2021 10:19 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,346,738					4.00
5.01	00550	ADMINISTRATION & GENERAL	2,011,015	-5,927,120	23,797,638			5.01
7.00	00700	OPERATION OF PLANT	220,339	0	889,623	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	7,972	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	97,184	182	0	8.00
9.00	00900	HOUSEKEEPING	172,992	0	278,283	456	201	9.00
10.00	01000	DIETARY	119,961	0	292,179	862	0	10.00
11.00	01100	CAFETERIA	86,639	0	152,677	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	91,300	0	183,878	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,258	0	407,847	787	0	16.00
17.00	01700	SOCIAL SERVICE	88,426	0	118,978	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	499,020	0	657,493	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,421,807	0	2,360,201	9,782	0	30.00
43.00	04300	NURSERY	176,762	0	303,849	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	451,116	0	1,135,234	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,252	0	128,675	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	649,461	0	1,472,329	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	173,166	310	0	56.00
60.00	06000	LABORATORY	664,627	0	2,283,267	1,688	0	60.00
60.02	06002	GEO PSYCH	132,931	0	198,099	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	50,374	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	210,677	0	352,905	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	141,740	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	50,977	0	131,228	1,125	0	69.00
69.01	06901	PULMONARY REHAB	48,891	0	81,615	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,272	0	87,959	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	157,204	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,178	0	1,224,944	1,251	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,323,169	0	6,711,054	0	6,665	88.00
90.00	09000	CLINIC	261,639	0	317,558	0	534	90.00
91.00	09100	EMERGENCY	472,257	0	2,392,514	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	74,855	0	109,256	0	656	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,749,821	-5,927,120	22,899,285	30,049	9,989	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,542	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	594,900	0	874,801	0	4,545	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	2,017	0	20,010	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,347,312		5,927,120	1,111,195	9,958	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.250796		0.249063	36.888590	0.685152	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		784,461	135,628	8,235	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.032964	4.502473	0.566602	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: 14-1305

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

Worksheet B-1

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	49,449					8.00
9.00	00900	HOUSEKEEPING	0	48,847				9.00
10.00	01000	DIETARY	0	862	2,375			10.00
11.00	01100	CAFETERIA	0	491	0	217,487		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	6,028	96,272	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	14,883	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	4,782	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,091	2,091	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,511	9,782	2,375	43,303	43,303	30.00
43.00	04300	NURSERY	0	225	0	5,981	5,981	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,921	4,007	0	13,125	13,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	1,260	1,260	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,486	4,429	0	20,701	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	27,117	0	60.00
60.02	06002	GEO PSYCH	0	972	0	5,505	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	7,554	7,554	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,827	1,827	69.00
69.01	06901	PULMONARY REHAB	0	961	0	2,113	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	414	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,251	0	4,694	4,694	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,194	10,797	0	39,672	0	88.00
90.00	09000	CLINIC	83	534	0	0	0	90.00
91.00	09100	EMERGENCY	5,254	1,852	0	14,029	14,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	656	0	2,408	2,408	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,449	44,228	2,375	217,487	96,272	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,545	0	0	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	128,103	364,552	403,181	212,479	247,317	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.590609	7.463140	169.760421	0.976973	2.568940	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,732	36,298	55,404	31,107	20,995	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.257477	0.743096	23.328000	0.143029	0.218080	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: 14-1305

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

Worksheet B-1

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY	55,775,696			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,902,348	98	0	30.00
43.00	04300	NURSERY	216,141	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,047,305	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	369,912	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,996,582	0	2,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,024,586	0	0	54.00
56.00	05600	RADIOISOTOPE	375,617	0	0	56.00
60.00	06000	LABORATORY	14,306,539	0	0	60.00
60.02	06002	GEO PSYCH	276,052	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,774	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	919,359	0	0	65.00
66.00	06600	PHYSICAL THERAPY	326,571	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	642,124	0	0	69.00
69.01	06901	PULMONARY REHAB	261,572	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,281,385	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	402,292	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,821,762	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,269,288	0	0	88.00
90.00	09000	CLINIC	211,966	0	0	90.00
91.00	09100	EMERGENCY	3,003,545	2	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	44,976	0	0	93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,775,696	100	2,080	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NAUV00 APARTMENTS	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	565,566	161,045	828,665	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010140	1,610.450000	398.396635	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,098	13,899	22,429	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001293	138.990000	10.783173	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: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
					Total Costs	Total Costs
					RCE Disallowance	
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,189,148		4,189,148	0
43.00	04300	NURSERY	412,906		412,906	0
46.00	04600	OTHER LONG TERM CARE	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,721,931		1,721,931	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,237		208,237	0
53.00	05300	ANESTHESIOLOGY	848,910		848,910	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,181,691		2,181,691	0
56.00	05600	RADIOISOTOPE	233,853		233,853	0
60.00	06000	LABORATORY	3,098,373		3,098,373	0
60.02	06002	GEO PSYCH	263,535		263,535	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,688		63,688	0
65.00	06500	RESPIRATORY THERAPY	507,556	0	507,556	0
66.00	06600	PHYSICAL THERAPY	191,840	0	191,840	0
69.00	06900	ELECTROCARDIOLOGY	226,797		226,797	0
69.01	06901	PULMONARY REHAB	114,488		114,488	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,722		137,722	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,437		200,437	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,640,914		1,640,914	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,598,568		8,598,568	0
90.00	09000	CLINIC	403,365		403,365	0
91.00	09100	EMERGENCY	3,167,575		3,167,575	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	329,871		329,871	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0
93.01	04950	DIABETIC EDUCATION	150,808		150,808	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	28,892,213	0	28,892,213	0
201.00		Less Observation Beds	329,871		329,871	0
202.00		Total (see instructions)	28,562,342	0	28,562,342	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/14/2021 10:19 am

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,265,338		3,265,338			30.00
43.00	04300	NURSERY	216,141		216,141			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	747,058	3,300,247	4,047,305	0.425451	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,663	137,249	369,912	0.562937	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	69,999	1,926,583	1,996,582	0.425182	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,393	10,563,193	11,024,586	0.197893	0.000000	54.00
56.00	05600	RADIOISOTOPE	7,437	368,180	375,617	0.622584	0.000000	56.00
60.00	06000	LABORATORY	1,450,586	12,855,953	14,306,539	0.216570	0.000000	60.00
60.02	06002	GEO PSYCH	0	276,052	276,052	0.954657	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,521	31,253	75,774	0.840499	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	432,075	487,284	919,359	0.552076	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	325,768	803	326,571	0.587437	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	29,286	612,838	642,124	0.353198	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	261,572	261,572	0.437692	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	529,260	752,125	1,281,385	0.107479	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,000	350,292	402,292	0.498238	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,697,095	2,124,667	3,821,762	0.429361	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	8,269,288	8,269,288			88.00
90.00	09000	CLINIC	0	211,966	211,966	1.902970	0.000000	90.00
91.00	09100	EMERGENCY	62,245	2,941,300	3,003,545	1.054612	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,728	629,282	637,010	0.517843	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	44,976	44,976	3.353077	0.000000	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,630,593	46,145,103	55,775,696			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,630,593	46,145,103	55,775,696			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.000000			60.00
60.02	06002	GEO PSYCH	0.000000			60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	PULMONARY REHAB	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.01	04950	DIABETIC EDUCATION	0.000000			93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/14/2021 10:19 am

			Title XIX		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	4,189,148		4,189,148	0	4,189,148	30.00
43.00	04300	NURSERY	412,906		412,906	0	412,906	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,721,931		1,721,931	0	1,721,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,237		208,237	0	208,237	52.00
53.00	05300	ANESTHESIOLOGY	848,910		848,910	0	848,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,181,691		2,181,691	0	2,181,691	54.00
56.00	05600	RADIOISOTOPE	233,853		233,853	0	233,853	56.00
60.00	06000	LABORATORY	3,098,373		3,098,373	0	3,098,373	60.00
60.02	06002	GEO PSYCH	263,535		263,535	0	263,535	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,688		63,688	0	63,688	62.00
65.00	06500	RESPIRATORY THERAPY	507,556	0	507,556	0	507,556	65.00
66.00	06600	PHYSICAL THERAPY	191,840	12,357	204,197	0	204,197	66.00
69.00	06900	ELECTROCARDIOLOGY	226,797		226,797	0	226,797	69.00
69.01	06901	PULMONARY REHAB	114,488		114,488	0	114,488	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,722		137,722	0	137,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,437		200,437	0	200,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,640,914		1,640,914	0	1,640,914	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,598,568		8,598,568	0	8,598,568	88.00
90.00	09000	CLINIC	403,365		403,365	0	403,365	90.00
91.00	09100	EMERGENCY	3,167,575		3,167,575	0	3,167,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	329,871		329,871	0	329,871	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	150,808		150,808	0	150,808	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,892,213	0	28,904,570	0	28,904,570	200.00
201.00		Less Observation Beds	329,871		329,871		329,871	201.00
202.00		Total (see instructions)	28,562,342	0	28,574,699	0	28,574,699	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/14/2021 10:19 am

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,265,338		3,265,338			30.00	
43.00	04300	NURSERY	216,141		216,141			43.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	747,058	3,300,247	4,047,305	0.425451	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	232,663	137,249	369,912	0.562937	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	69,999	1,926,583	1,996,582	0.425182	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,393	10,563,193	11,024,586	0.197893	0.000000	54.00	
56.00	05600	RADIOISOTOPE	7,437	368,180	375,617	0.622584	0.000000	56.00	
60.00	06000	LABORATORY	1,450,586	12,855,953	14,306,539	0.216570	0.000000	60.00	
60.02	06002	GEO PSYCH	0	276,052	276,052	0.954657	0.000000	60.02	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,521	31,253	75,774	0.840499	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	432,075	487,284	919,359	0.552076	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	325,768	803	326,571	0.587437	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	29,286	612,838	642,124	0.353198	0.000000	69.00	
69.01	06901	PULMONARY REHAB	0	261,572	261,572	0.437692	0.000000	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	529,260	752,125	1,281,385	0.107479	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,000	350,292	402,292	0.498238	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,697,095	2,124,667	3,821,762	0.429361	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	8,269,288	8,269,288	1.039820	0.000000	88.00	
90.00	09000	CLINIC	0	211,966	211,966	1.902970	0.000000	90.00	
91.00	09100	EMERGENCY	62,245	2,941,300	3,003,545	1.054612	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,728	629,282	637,010	0.517843	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00	
93.01	04950	DIABETIC EDUCATION	0	44,976	44,976	3.353077	0.000000	93.01	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	9,630,593	46,145,103	55,775,696			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	9,630,593	46,145,103	55,775,696			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.425451			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562937			52.00
53.00	05300	ANESTHESIOLOGY	0.425182			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197893			54.00
56.00	05600	RADIOISOTOPE	0.622584			56.00
60.00	06000	LABORATORY	0.216570			60.00
60.02	06002	GEO PSYCH	0.954657			60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.840499			62.00
65.00	06500	RESPIRATORY THERAPY	0.552076			65.00
66.00	06600	PHYSICAL THERAPY	0.625276			66.00
69.00	06900	ELECTROCARDIOLOGY	0.353198			69.00
69.01	06901	PULMONARY REHAB	0.437692			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107479			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498238			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429361			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.039820			88.00
90.00	09000	CLINIC	1.902970			90.00
91.00	09100	EMERGENCY	1.054612			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.517843			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.01	04950	DIABETIC EDUCATION	3.353077			93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,721,931	264,012	1,457,919	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	208,237	52,222	156,015	0	0	52.00
53.00	05300 ANESTHESIOLOGY	848,910	2,582	846,328	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,181,691	302,348	1,879,343	0	0	54.00
56.00	05600 RADIOISOTOPE	233,853	22,655	211,198	0	0	56.00
60.00	06000 LABORATORY	3,098,373	187,258	2,911,115	0	0	60.00
60.02	06002 GEO PSYCH	263,535	24,111	239,424	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	63,688	1,759	61,929	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	507,556	52,241	455,315	0	0	65.00
66.00	06600 PHYSICAL THERAPY	191,840	18,847	172,993	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	226,797	65,554	161,243	0	0	69.00
69.01	06901 PULMONARY REHAB	114,488	19,581	94,907	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	137,722	21,926	115,796	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	200,437	5,702	194,735	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,640,914	113,446	1,527,468	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	8,598,568	418,987	8,179,581	0	0	88.00
90.00	09000 CLINIC	403,365	19,794	383,571	0	0	90.00
91.00	09100 EMERGENCY	3,167,575	187,792	2,979,783	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	329,871	54,510	275,361	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	150,808	15,622	135,186	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	24,290,159	1,850,949	22,439,210	0	0	200.00
201.00	Less Observation Beds	329,871	54,510	275,361	0	0	201.00
202.00	Total (line 200 minus line 201)	23,960,288	1,796,439	22,163,849	0	0	202.00

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

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,721,931	4,047,305	0.425451		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	208,237	369,912	0.562937		52.00
53.00	05300 ANESTHESIOLOGY	848,910	1,996,582	0.425182		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,181,691	11,024,586	0.197893		54.00
56.00	05600 RADIOISOTOPE	233,853	375,617	0.622584		56.00
60.00	06000 LABORATORY	3,098,373	14,306,539	0.216570		60.00
60.02	06002 GEO PSYCH	263,535	276,052	0.954657		60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	63,688	75,774	0.840499		62.00
65.00	06500 RESPIRATORY THERAPY	507,556	919,359	0.552076		65.00
66.00	06600 PHYSICAL THERAPY	191,840	326,571	0.587437		66.00
69.00	06900 ELECTROCARDIOLOGY	226,797	642,124	0.353198		69.00
69.01	06901 PULMONARY REHAB	114,488	261,572	0.437692		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	137,722	1,281,385	0.107479		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	200,437	402,292	0.498238		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,640,914	3,821,762	0.429361		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	8,598,568	8,269,288	1.039820		88.00
90.00	09000 CLINIC	403,365	211,966	1.902970		90.00
91.00	09100 EMERGENCY	3,167,575	3,003,545	1.054612		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	329,871	637,010	0.517843		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04950 DIABETIC EDUCATION	150,808	44,976	3.353077		93.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0.000000		95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	24,290,159	52,294,217			200.00
201.00	Less Observation Beds	329,871	0			201.00
202.00	Total (line 200 minus line 201)	23,960,288	52,294,217			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	264,012	4,047,305	0.065232	193,862	12,646
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,222	369,912	0.141174	0	0
53.00	05300	ANESTHESIOLOGY	2,582	1,996,582	0.001293	65,727	85
54.00	05400	RADIOLOGY-DIAGNOSTIC	302,348	11,024,586	0.027425	258,378	7,086
56.00	05600	RADIOISOTOPE	22,655	375,617	0.060314	5,481	331
60.00	06000	LABORATORY	187,258	14,306,539	0.013089	586,781	7,680
60.02	06002	GEO PSYCH	24,111	276,052	0.087342	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,759	75,774	0.023214	30,229	702
65.00	06500	RESPIRATORY THERAPY	52,241	919,359	0.056823	215,968	12,272
66.00	06600	PHYSICAL THERAPY	18,847	326,571	0.057712	2,296	133
69.00	06900	ELECTROCARDIOLOGY	65,554	642,124	0.102089	13,717	1,400
69.01	06901	PULMONARY REHAB	19,581	261,572	0.074859	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,926	1,281,385	0.017111	225,758	3,863
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,702	402,292	0.014174	51,677	732
73.00	07300	DRUGS CHARGED TO PATIENTS	113,446	3,821,762	0.029684	840,116	24,938
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	418,987	8,269,288	0.050668	0	0
90.00	09000	CLINIC	19,794	211,966	0.093383	0	0
91.00	09100	EMERGENCY	187,792	3,003,545	0.062523	36,485	2,281
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,510	637,010	0.085572	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0
93.01	04950	DIABETIC EDUCATION	15,622	44,976	0.347341	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	1,850,949	52,294,217		2,526,475	74,149

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

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

Worksheet D
Part IV
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	828,665	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	828,665	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/14/2021 10:19 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,047,305	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	369,912	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	828,665	0	1,996,582	0.415042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,024,586	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	375,617	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	14,306,539	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	276,052	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	75,774	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	919,359	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	326,571	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	642,124	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	261,572	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,281,385	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	402,292	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,821,762	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,269,288	0.000000	88.00
90.00	09000	CLINIC	0	0	0	211,966	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,003,545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	637,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	44,976	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	828,665	0	52,294,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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	193,862	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	65,727	27,279	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	258,378	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	5,481	0	0	0	56.00
60.00	06000 LABORATORY	0.000000	586,781	0	0	0	60.00
60.02	06002 GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	30,229	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	215,968	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,296	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	13,717	0	0	0	69.00
69.01	06901 PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	225,758	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	51,677	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	840,116	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	36,485	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		2,526,475	27,279	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/14/2021 10:19 am

			Title XVIII		Hospital		Cost	
	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	0.425451	0	1,107,615	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562937	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.425182	0	478,793	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197893	0	3,953,495	0	0	54.00
56.00	05600	RADIOISOTOPE	0.622584	0	153,898	0	0	56.00
60.00	06000	LABORATORY	0.216570	0	4,480,975	0	0	60.00
60.02	06002	GEO PSYCH	0.954657	0	240,134	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.840499	0	20,635	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.552076	0	169,573	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587437	0	379	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.353198	0	192,724	0	0	69.00
69.01	06901	PULMONARY REHAB	0.437692	0	187,459	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107479	0	85,139	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498238	0	121,895	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429361	0	948,030	128	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.902970	0	109,904	0	0	90.00
91.00	09100	EMERGENCY	1.054612	0	1,045,680	18,772	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.517843	0	255,371	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.353077	0	19,674	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	13,571,373	18,900	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,571,373	18,900	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/14/2021 10:19 am

			Title XVIII	Hospital	Cost
	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	471,236	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	203,574	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	782,369	0	54.00
56.00	05600	RADIOISOTOPE	95,814	0	56.00
60.00	06000	LABORATORY	970,445	0	60.00
60.02	06002	GEO PSYCH	229,246	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,344	0	62.00
65.00	06500	RESPIRATORY THERAPY	93,617	0	65.00
66.00	06600	PHYSICAL THERAPY	223	0	66.00
69.00	06900	ELECTROCARDIOLOGY	68,070	0	69.00
69.01	06901	PULMONARY REHAB	82,049	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,151	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,733	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,047	55	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	209,144	0	90.00
91.00	09100	EMERGENCY	1,102,787	19,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	132,242	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	65,968	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,001,059	19,852	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,001,059	19,852	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:

From 01/01/2020

To 12/31/2020

Worksheet D

Part IV

Date/Time Prepared:

7/14/2021 10:19 am

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	828,665	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	828,665	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

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

Part IV
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			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	4,047,305	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	369,912	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	828,665	0	1,996,582	0.415042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,024,586	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	375,617	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	14,306,539	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	276,052	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	75,774	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	919,359	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	326,571	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	642,124	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	261,572	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,281,385	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	402,292	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,821,762	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,269,288	0.000000	88.00
90.00	09000	CLINIC	0	0	0	211,966	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,003,545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	637,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	44,976	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	828,665	0	52,294,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

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

Part IV
Date/Time Prepared:
7/14/2021 10:19 am

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)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	220	91	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	29,692	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	1,956	0	0	0	56.00
60.00	06000 LABORATORY	0.000000	164,032	0	0	0	60.00
60.02	06002 GEO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,270	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	107,514	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	283,118	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,025	0	0	0	69.00
69.01	06901 PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	89,928	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	203,912	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	1,420	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950 DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		887,087	91	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/14/2021 10:19 am

			Title XVIII	Swing Beds - SNF		Cost		
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	0.425451	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562937	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.425182	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197893	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.622584	0	0	0	0	56.00
60.00	06000	LABORATORY	0.216570	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.954657	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.840499	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.552076	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587437	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.353198	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.437692	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107479	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429361	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.902970	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.054612	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.517843	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.353077	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305

Period:

Worksheet D

Component CCN: 14-Z305

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/14/2021 10:19 am

			Title XVIII		Swing Beds - SNF		Cost		
	Cost Center Description		Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
60.00	06000	LABORATORY	0	0					60.00
60.02	06002	GEO PSYCH	0	0					60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	06901	PULMONARY REHAB	0	0					69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0					93.00
93.01	04950	DIABETIC EDUCATION	0	0					93.01
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/14/2021 10:19 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		692,234	241,874	450,360	1,659	271.46	30.00
43.00	NURSERY		24,401		24,401	240	101.67	43.00
200.00	Total (lines 30 through 199)		716,635		474,761	1,899		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		158	42,891				
43.00	NURSERY		114	11,590				
200.00	Total (lines 30 through 199)		272	54,481				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	264,012	4,047,305	0.065232	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,222	369,912	0.141174	0	0 52.00
53.00	05300	ANESTHESIOLOGY	2,582	1,996,582	0.001293	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	302,348	11,024,586	0.027425	0	0 54.00
56.00	05600	RADIOISOTOPE	22,655	375,617	0.060314	0	0 56.00
60.00	06000	LABORATORY	187,258	14,306,539	0.013089	0	0 60.00
60.02	06002	GEO PSYCH	24,111	276,052	0.087342	0	0 60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,759	75,774	0.023214	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	52,241	919,359	0.056823	0	0 65.00
66.00	06600	PHYSICAL THERAPY	18,847	326,571	0.057712	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	65,554	642,124	0.102089	0	0 69.00
69.01	06901	PULMONARY REHAB	19,581	261,572	0.074859	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,926	1,281,385	0.017111	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,702	402,292	0.014174	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,446	3,821,762	0.029684	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	418,987	8,269,288	0.050668	0	0 88.00
90.00	09000	CLINIC	19,794	211,966	0.093383	0	0 90.00
91.00	09100	EMERGENCY	187,792	3,003,545	0.062523	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,510	637,010	0.085572	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0 93.00
93.01	04950	DIABETIC EDUCATION	15,622	44,976	0.347341	0	0 93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,850,949	52,294,217		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1305		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/14/2021 10:19 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
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	1,659	0.00	158			30.00	
43.00	04300	NURSERY	0	0	240	0.00	114			43.00	
200.00		Total (lines 30 through 199)	0	0	1,899		272			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
43.00	04300	NURSERY	0							43.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

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

Worksheet D
Part IV
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	828,665	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	828,665	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/14/2021 10:19 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,047,305	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	369,912	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	828,665	0	1,996,582	0.415042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,024,586	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	375,617	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	14,306,539	0.000000	60.00
60.02	06002	GEO PSYCH	0	0	0	276,052	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	75,774	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	919,359	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	326,571	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	642,124	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	261,572	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,281,385	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	402,292	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,821,762	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,269,288	0.000000	88.00
90.00	09000	CLINIC	0	0	0	211,966	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,003,545	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	637,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	44,976	0.000000	93.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	828,665	0	52,294,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1305

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

Worksheet D
Part IV
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
60.02	06002	GEO PSYCH	0.000000	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	93.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/14/2021 10:19 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,576	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,659	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,458	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		891	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		26	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)		906	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)		797	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		161.50	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		161.50	20.00	
21.00	Total general inpatient routine service cost (see instructions)		4,189,148	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)		4,199	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)		1,466,473	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,722,675	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)		2,722,675	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)		1,641.16	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,486,891	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,486,891	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
7/14/2021 10:19 am

		Title XVIII		Hospital		Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					892,081	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,378,972	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,308,005	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)					1,308,005	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)					201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,641.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					329,871	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
7/14/2021 10:19 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	692,234	4,189,148	0.165245	329,871	54,510
91.00	Nursing School cost	0	4,189,148	0.000000	329,871	0
92.00	Allied health cost	0	4,189,148	0.000000	329,871	0
93.00	All other Medical Education	0	4,189,148	0.000000	329,871	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/14/2021 10:19 am	
		Title XIX	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)			2,576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,659	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,458	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			891	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			26	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)			158	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)			240	15.00
16.00	Nursery days (title V or XIX only)			114	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,189,148	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)			1,463,735	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,725,413	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)			2,725,413	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)			1,642.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			259,562	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)			259,562	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)	412,906	240	1,720.44	114	196,130	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					455,692	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)					54,481	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					54,481	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					401,211	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)					201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,642.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					330,203	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1305

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

Worksheet D-1

Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Title XIX		Hospital	PPS	
		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	692,234	4,189,148	0.165245	330,203	54,564
91.00	Nursing School cost	0	4,189,148	0.000000	330,203	0
92.00	Allied health cost	0	4,189,148	0.000000	330,203	0
93.00	All other Medical Education	0	4,189,148	0.000000	330,203	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/14/2021 10:19 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,444,756	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.425451	193,862	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562937	0	52.00
53.00	05300	ANESTHESIOLOGY	0.425182	65,727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197893	258,378	54.00
56.00	05600	RADIOISOTOPE	0.622584	5,481	56.00
60.00	06000	LABORATORY	0.216570	586,781	60.00
60.02	06002	GEO PSYCH	0.954657	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.840499	30,229	62.00
65.00	06500	RESPIRATORY THERAPY	0.552076	215,968	65.00
66.00	06600	PHYSICAL THERAPY	0.587437	2,296	66.00
69.00	06900	ELECTROCARDIOLOGY	0.353198	13,717	69.00
69.01	06901	PULMONARY REHAB	0.437692	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107479	225,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498238	51,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429361	840,116	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	1.902970	0	90.00
91.00	09100	EMERGENCY	1.054612	36,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.517843	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	3.353077	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,526,475	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,526,475	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1305 Component CCN: 14-Z305	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/14/2021 10:19 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.425451	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.562937	0	52.00
53.00	05300	ANESTHESIOLOGY	0.425182	220	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197893	29,692	54.00
56.00	05600	RADIOISOTOPE	0.622584	1,956	56.00
60.00	06000	LABORATORY	0.216570	164,032	60.00
60.02	06002	GEO PSYCH	0.954657	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.840499	3,270	62.00
65.00	06500	RESPIRATORY THERAPY	0.552076	107,514	65.00
66.00	06600	PHYSICAL THERAPY	0.587437	283,118	66.00
69.00	06900	ELECTROCARDIOLOGY	0.353198	2,025	69.00
69.01	06901	PULMONARY REHAB	0.437692	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107479	89,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498238	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429361	203,912	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	1.902970	0	90.00
91.00	09100	EMERGENCY	1.054612	1,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.517843	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	3.353077	0	93.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		887,087	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		887,087	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/14/2021 10:19 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,020,911	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,020,911	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,071,120	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		33,801	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,801,765	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,235,554	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,235,554	30.00
31.00	Primary payer payments		514	31.00
32.00	Subtotal (line 30 minus line 31)		3,235,040	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)		339,867	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		220,914	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		194,998	36.00
37.00	Subtotal (see instructions)		3,455,954	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,455,954	40.00
40.01	Sequestration adjustment (see instructions)		22,809	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,135,394	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)		297,751	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: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/14/2021 10:19 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,218,395		3,021,277	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/12/2020	6,055	08/12/2020	114,117	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)		6,055		114,117	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,224,450		3,135,394	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		297,751	6.01
6.02	SETTLEMENT TO PROGRAM		55,031		0	6.02
7.00	Total Medicare program liability (see instructions)		2,169,419		3,433,145	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1305

Period:

Worksheet E-1

Component CCN: 14-Z305

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/14/2021 10:19 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,942,241		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	08/12/2020	17,863		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)		-17,863		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,924,378		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		253,763		0	6.02
7.00	Total Medicare program liability (see instructions)		1,670,615		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/14/2021 10:19 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1305 Component CCN: 14-Z305	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2 Date/Time Prepared: 7/14/2021 10:19 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,321,085	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		374,357	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		797	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,695,442	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,695,442	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,695,442	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		13,728	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,681,714	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,681,714	0	19.00
19.01	Sequestration adjustment (see instructions)		11,099	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,924,378	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-253,763	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/14/2021 10:19 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,378,972	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,378,972	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,402,762	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,402,762	19.00
20.00	Deductibles (exclude professional component)		239,316	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,163,446	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,163,446	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		31,363	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		20,386	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,469	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,183,832	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,183,832	30.00
30.01	Sequestration adjustment (see instructions)		14,413	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,224,450	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-55,031	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1305

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

Worksheet G

Date/Time Prepared:
7/14/2021 10:19 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	13,284,018	0	0	0	1.00
2.00	Temporary investments	48,902	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,273,798	0	0	0	4.00
5.00	Other receivable	525,671	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	415,028	0	0	0	7.00
8.00	Prepaid expenses	248,003	0	0	0	8.00
9.00	Other current assets	24,244	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)	20,819,664	0	0	0	11.00
FIXED ASSETS						
12.00	Land	499,957	0	0	0	12.00
13.00	Land improvements	1,397,947	0	0	0	13.00
14.00	Accumulated depreciation	-598,616	0	0	0	14.00
15.00	Buildings	25,234,525	0	0	0	15.00
16.00	Accumulated depreciation	-14,215,123	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,469,648	0	0	0	23.00
24.00	Accumulated depreciation	-6,136,024	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,775,183	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)	14,845,900	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,612,228	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	1,021,609	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,633,837	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,299,401	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,604,019	0	0	0	37.00
38.00	Salaries, wages, and fees payable	763,380	0	0	0	38.00
39.00	Payroll taxes payable	288,377	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,360,066	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	4,257,148	0	0	0	42.00
43.00	Due to other funds	2,625,800	0	0	0	43.00
44.00	Other current liabilities	64,795	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,963,585	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	19,060,925	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	443,861	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,504,786	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,468,371	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,831,030				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,831,030	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,299,401	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1305

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

Worksheet G-1

Date/Time Prepared:
7/14/2021 10:19 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		11,277,547		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,419,544				2.00
3.00	Total (sum of line 1 and line 2)		12,697,091		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	133,939		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)		133,939		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,831,030		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,831,030		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	RESTRICTED CONTRIBUTIONS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1305

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/14/2021 10:19 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,925,176		3,925,176	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	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,925,176		3,925,176	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,925,176		3,925,176	17.00
18.00	Ancillary services	6,042,947	33,720,142	39,763,089	18.00
19.00	Outpatient services	70,262	8,398,641	8,468,903	19.00
20.00	RURAL HEALTH CLINIC	0	8,269,288	8,269,288	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	879,139	879,139	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,038,385	51,267,210	61,305,595	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,050,543		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)		32,050,543		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1305

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

Worksheet G-3

Date/Time Prepared:
7/14/2021 10:19 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,305,595	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,631,982	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,673,613	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,050,543	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,376,930	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	172,763	6.00
7.00	Income from investments	329,820	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	25,034	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	53,931	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,476	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	69,281	22.00
23.00	Governmental appropriations	143,323	23.00
24.00	HOSPITAL OTHER INCOME	8,872	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	RELEASED FROM RESTRICTION	0	24.03
24.04	340B PHARMACY REVENUE	1,614,800	24.04
24.05	SALARY REIMBURSEMENTS	42,822	24.05
24.06	EHR INCENTIVE	0	24.06
24.07	EQUITY IN EARNINGS OF UNCONSOLIDATED	44,440	24.07
24.50	COVID-19 PHE Funding	296,768	24.50
25.00	Total other income (sum of lines 6-24)	2,804,330	25.00
26.00	Total (line 5 plus line 25)	1,427,400	26.00
27.00	LOSS ON DISPOSAL	7,856	27.00
27.01	EQUITY IN EARNINGS OF UNCONSOLIDATED	0	27.01
27.02	OTHER LOSS ON DISPOSAL	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	7,856	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,419,544	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/14/2021 10:19 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,696,338	0	1,696,338	-193,552	1,502,786
2.00	Physician Assistant	160,602	0	160,602	-299	160,303
3.00	Nurse Practitioner	1,037,172	0	1,037,172	-104,914	932,258
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
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	1,681,556	0	1,681,556	50,520	1,732,076
10.00	Subtotal (sum of lines 1 through 9)	4,575,668	0	4,575,668	-248,245	4,327,423
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	170,388	170,388	0	170,388
13.00	Other Costs Under Agreement	0	117,053	117,053	0	117,053
14.00	Subtotal (sum of lines 11 through 13)	0	287,441	287,441	0	287,441
15.00	Medical Supplies	0	480,775	480,775	0	480,775
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	102,024	102,024	0	102,024
19.00	Other Health Care Costs	0	171,538	171,538	0	171,538
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	754,337	754,337	0	754,337
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,575,668	1,041,778	5,617,446	-248,245	5,369,201
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	46,266	46,266
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	46,266	46,266
FACILITY OVERHEAD						
29.00	Facility Costs	0	92,221	92,221	0	92,221
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	92,221	92,221	0	92,221
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,575,668	1,133,999	5,709,667	-201,979	5,507,688

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305

Period:

Worksheet M-1

Component CCN: 14-3456

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/14/2021 10:19 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	1,502,786	1.00
2.00	Physician Assistant	0	160,303	2.00
3.00	Nurse Practitioner	0	932,258	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	1,732,076	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,327,423	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	170,388	12.00
13.00	Other Costs Under Agreement	0	117,053	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	287,441	14.00
15.00	Medical Supplies	0	480,775	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	-22,944	79,080	18.00
19.00	Other Health Care Costs	-26,706	144,832	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-49,650	704,687	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-49,650	5,319,551	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	46,266	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	46,266	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	92,221	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	92,221	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-49,650	5,458,038	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305

Period:

Worksheet M-2

Component CCN: 14-3456

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/14/2021 10:19 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	2.49	8,912	4,200	10,458		1.00
2.00	Physician Assistant	0.68	5,363	2,100	1,428		2.00
3.00	Nurse Practitioner	5.14	13,041	2,100	10,794		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.31	27,316		22,680	27,316	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.31	27,316			27,316	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					5,319,551	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					46,266	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,365,817	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.991378	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					92,221	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,140,530	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,232,751	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,232,751	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,204,878	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,524,429	20.00

Health Financial Systems		MEMORIAL HOSPITAL ASSOCIATION		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1305	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-3456		Date/Time Prepared: 7/14/2021 10:19 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)			8,524,429	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			257,501	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,266,928	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			27,316	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)			27,316	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			302.64	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		302.64	302.64	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	5,224	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,580,991	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	1,580,991	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,210,816	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			109,603	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			143,111	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,043,690	16.04
16.05	Total program cost (see instructions)		0	1,186,801	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			133,268	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			193,457	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,186,801	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			91,268	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,278,069	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,278,069	26.00
26.01	Sequestration adjustment (see instructions)			8,435	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,030,595	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)			239,039	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: 14-1305 Component CCN: 14-3456	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/14/2021 10:19 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)		4,327,423	4,327,423	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001518	0.002950	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		6,569	12,766	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		89,409	51,944	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		95,978	64,710	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		5,319,551	5,319,551	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,204,878	3,204,878	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.018043	0.012165	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		57,826	38,987	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		153,804	103,697	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		630	1,224	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		244.13	84.72	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		234	403	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		57,126	34,142	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)			257,501	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)			91,268	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/14/2021 10:19 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		1,057,187	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		08/12/2020	26,592	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)		-26,592	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,030,595	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		239,039	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,269,634	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00