

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: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/7/2021 12:52 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/7/2021	Time: 12:52 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (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 HOOPESTON COMMUNITY MEMORIAL HOSPITA (14-1316) 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	230,314	616,653	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	137,880	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,071,630		0	10.00
200.00	Total	0	368,194	1,688,283	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: 14-1316		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/7/2021 12:52 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 701 EAST ORANGE			PO Box:				1.00		
2.00	City: HOOPESTON			State: IL		Zip Code: 60942		County: VERMILION		
		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		HOOPESTON COMMUNITY MEMORIAL HOSPITAL	141316	19180	1	11/01/2001	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HOOPESTON CMH SWING BED	14Z316	19180		11/01/2001	N	O	N
8.00	Swing Beds - NF									
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		HOOPESTON MEDICAL CENTER RHC	143448	19180		04/01/1998	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020		12/31/2020	
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.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1316

Period:
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Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1316		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/7/2021 12:52 pm			
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N			60.00		
				Y/N	IME	Direct GME			
				1.00	2.00	3.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			N		0.00	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	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	61.20		
							1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						62.00		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
				1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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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	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/7/2021 12:52 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	411,059	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H077	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1316		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/7/2021 12:52 pm				
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: CARLE HEALTH SYSTEMS		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00450		141.00					
142.00	Street: 611 WEST PARK STREET		PO Box:				142.00					
143.00	City: URBANA		State: IL		Zip Code: 61801		143.00					
								1.00				
144.00 Are provider based physicians' costs included in Worksheet A?								Y		144.00		
								1.00				
								2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00				
								1.00				
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N		147.00		
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N		148.00		
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N		149.00		
				Part A		Part B		Title V		Title XIX		
				1.00		2.00		3.00		4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)												
155.00	Hospital			N	N	N	N	155.00				
156.00	Subprovider - IPF			N	N	N	N	156.00				
157.00	Subprovider - IRF			N	N	N	N	157.00				
158.00	SUBPROVIDER							158.00				
159.00	SNF			N	N	N	N	159.00				
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00				
161.00	CMHC				N	N	N	161.00				
161.10	CORF				N	N	N	161.10				
161.20	OUTPATIENT PHYSICAL THERAPY				N	N	N	161.20				
161.30	OUTPATIENT OCCUPATIONAL THERAPY				N	N	N	161.30				
161.40	OUTPATIENT SPEECH PATHOLOGY				N	N	N	161.40				
								1.00				
Multicampus												
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N		165.00		
				Name		County		State		Zip Code	CBSA	FTE/Campus
				0		1.00		2.00		3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									0.00	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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/7/2021 12:52 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/7/2021 12:52 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/01/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/7/2021 12:52 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y	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.	LUCAS	MORTON	41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-902-6326	LUCAS.MORTON@CARLE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1316

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.	FINANCE DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,052	23,052.00	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)		22	8,052	23,052.00	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						13.00
14.00 Total (see instructions)		22	8,052	23,052.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 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)		22				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: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	375	13	887			1.00
2.00	HMO and other (see instructions)	0	123				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	267	0	267			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		324	324			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	642	337	1,478			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)	642	337	1,478	0.00	102.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RHC (CONSOLIDATED)	18,432	49,620	148,757	0.00	188.44	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	290.86	27.00
28.00	Observation Bed Days		0	873			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	136	4	305	1.00
2.00 HMO and other (see instructions)			0	36		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	136	4	305	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 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

Health Financial Systems		HOOPESTON COMMUNITY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1316 Component CCN: 14-3448		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/7/2021 12:52 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		801 EAST ORANGE STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		HOOPESTON IL 60452		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				9.00
					1.00 2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
				5.00	
11.00	Facility hours of operations (1)				
	CLINIC	09:00	08:00	20:00	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		8 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		CHARLOTTE RUSSEL		143448 14.00
14.01			CISSNA PARK		143485 14.01
14.02			ROSSVILLE		143496 14.02
14.03			ROBERTS CLINIC		148521 14.03
14.04			MILFORD CLINIC		148526 14.04
14.05			DANVILLE CLINIC		148531 14.05
14.06			CARLE AT TUSCOLA		148533 14.06
14.07			CARLE MATTOON		148544 14.07
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
					15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1316
 Component CCN: 14-3448

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

 Worksheet S-8
 Date/Time Prepared:
 7/7/2021 12:52 pm

						RHC I		Cost		
				County						
				4.00						
2.00	City, State, ZIP Code, County			VERMILLION					2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
11.00	Facility hours of operations (1)									11.00
	CLINIC			20:00	08:00	20:00	08:00	20:00		
				Friday		Saturday				
				from to		from to				
				11.00 12.00		13.00 14.00				
11.00	Facility hours of operations (1)									
	CLINIC			08:00	20:00	09:00	17:00		11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/7/2021 12:52 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.542940	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			12,703,167	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			29,478,072	6.00
7.00	Medicaid cost (line 1 times line 6)			16,004,824	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			3,301,657	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			3,301,657	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,907,553	0	4,907,553	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,664,507	0	2,664,507	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,664,507	0	2,664,507	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,582,583	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			660,490	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,016,138	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,566,445	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,206,134	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,870,641	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,172,298	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1316

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

Worksheet A

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		909,344	909,344	390,368	1,299,712	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		829,844	829,844	0	829,844	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,615,610	17,828,198	20,443,808	433,115	20,876,923	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	635,732	875,975	1,511,707	17,474	1,529,181	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	80,380	80,380	8.00
9.00	00900	HOUSEKEEPING	275,366	209,044	484,410	-80,380	404,030	9.00
10.00	01000	DIETARY	162,431	192,105	354,536	0	354,536	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	292,212	78,166	370,378	0	370,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	133,416	133,416	-26,118	107,298	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,156,277	983,963	2,140,240	0	2,140,240	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	444,972	310,206	755,178	-2,876	752,302	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	961,266	1,550,902	2,512,168	0	2,512,168	54.00
60.00	06000	LABORATORY	629,198	1,705,704	2,334,902	0	2,334,902	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	436,189	166,009	602,198	0	602,198	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,118	26,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,876	2,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,365	978,685	1,019,050	0	1,019,050	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,084,786	18,609,520	28,694,306	-730,533	27,963,773	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,305,772	2,192,374	3,498,146	-110,424	3,387,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,040,176	47,553,455	66,593,631	0	66,593,631	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	2,711,382	2,711,382	0	2,711,382	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,040,176	50,264,837	69,305,013	0	69,305,013	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet A
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,144,907	4,444,619	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	829,844	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-279,801	-279,801	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,613,098	17,263,825	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,588,391	3,117,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,380	8.00
9.00	00900	HOUSEKEEPING	0	404,030	9.00
10.00	01000	DIETARY	-30,208	324,328	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,146,177	1,516,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122,079	229,377	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	309,325	309,325	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-573,998	1,566,242	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	752,302	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-565,420	1,946,748	54.00
60.00	06000	LABORATORY	420,062	2,754,964	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00	06600	PHYSICAL THERAPY	38,858	641,056	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,393	1,415,443	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	89,091	28,052,864	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,239,659	2,148,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	953,099	67,546,730	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	RETAIL PHARMACY	0	2,711,382	192.01
193.01	19301	MATTOON CLINIC	0	0	193.01
194.00	07950	FOUNDATION	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	953,099	70,258,112	200.00

RECLASSIFICATIONS

Provider CCN: 14-1316

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

Worksheet A-6

Date/Time Prepared:
7/7/2021 12:52 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	381,409	1.00	
	TOTALS		0	381,409		
	B - SURGERY SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,118	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,876	2.00	
	TOTALS		0	28,994		
	C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,959	1.00	
	TOTALS		0	8,959		
	D - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	17,474	1.00	
	TOTALS		0	17,474		
	F - INSURANCE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	110,424	1.00	
	TOTALS		0	110,424		
	G - RHC ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	554,459	158,600	1.00	
	TOTALS		554,459	158,600		
	H - LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	80,380	1.00	
	TOTALS		0	80,380		
500.00	Grand Total: Increases		554,459	786,240	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1316

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

Worksheet A-6

Date/Time Prepared:
7/7/2021 12:52 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - INTEREST EXPENSE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	381,409	11		
	TOTALS		0	381,409			
	B - SURGERY SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,118	0		1.00
2.00	OPERATING ROOM	50.00	0	2,876	0		2.00
	TOTALS		0	28,994			
	C - CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,959	11		1.00
	TOTALS		0	8,959			
	D - UTILITY EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	17,474	0		1.00
	TOTALS		0	17,474			
	F - INSURANCE EXPENSE						
1.00	EMERGENCY	91.00	0	110,424	0		1.00
	TOTALS		0	110,424			
	G - RHC ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	554,459	158,600	0		1.00
	TOTALS		554,459	158,600			
	H - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	0	80,380	0		1.00
	TOTALS		0	80,380			
500.00	Grand Total: Decreases		554,459	786,240			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

		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	110,211	0	0	0	0	1.00	
2.00	Land Improvements	1,107,068	85,250	0	85,250	0	2.00	
3.00	Buildings and Fixtures	13,688,736	996,231	0	996,231	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	11,890,791	1,391,379	0	1,391,379	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	26,796,806	2,472,860	0	2,472,860	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	26,796,806	2,472,860	0	2,472,860	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	110,211	0				1.00	
2.00	Land Improvements	1,192,318	0				2.00	
3.00	Buildings and Fixtures	14,684,967	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	13,282,170	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	29,269,666	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	29,269,666	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	909,344	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	829,844	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,739,188	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	909,344				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	829,844				2.00
3.00	Total (sum of lines 1-2)	0	1,739,188				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	14,684,967	0	14,684,967	0.525079	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,282,170	0	13,282,170	0.474921	0	2.00
3.00	Total (sum of lines 1-2)	27,967,137	0	27,967,137	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,069,253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	829,844	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,899,097	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	375,366	0	0	0	4,444,619	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	829,844	2.00
3.00	Total (sum of lines 1-2)	375,366	0	0	0	5,274,463	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1316

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

Worksheet A-8

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		A	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-15,002	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,379,077			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	4,798,578			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-29,389	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CATERING	B	-9,520	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1316

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

Worksheet A-8

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
35.00	LOBBYING EXPENSE	A		1 ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER REVENUE	B	-7,362	RURAL HEALTH CLINIC	88.00	0	36.00
39.00	MAINTENANCE	B	-93,403	OPERATION OF PLANT	7.00	0	39.00
40.00	OTHER INCOME	B	-12,347	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PROVIDER TAX	A	-1,380,502	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING	A	-1,134	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	BILLING REVENUE	B	-14,197	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00	CPG BENEFITS AT COST	A	96,453	RURAL HEALTH CLINIC	88.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		953,099				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: 14-1316

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

Worksheet A-8-1

Date/Time Prepared:
7/7/2021 12:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	10,832,640	13,037,559	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL	3,159,909	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	CARLE SERVICES	503,426	503,426	3.00
3.01	60.00	LABORATORY	CARLE SERVICES	1,450,217	1,030,155	3.01
3.02	88.00	RURAL HEALTH CLINIC	CARLE SERVICES	149,084	149,084	3.02
3.03	10.00	DIETARY	CARLE SERVICES	30,036	21,335	3.03
3.04	66.00	PHYSICAL THERAPY	CARLE SERVICES	393,388	354,530	3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	-279,802	0	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	309,325	0	3.06
3.07	7.00	OPERATION OF PLANT	HOME OFFICE	1,681,794	0	3.07
3.08	13.00	NURSING ADMINISTRATION	HOME OFFICE	1,146,177	0	3.08
3.09	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	122,079	0	3.09
3.12	73.00	DRUGS CHARGED TO PATIENTS	CARLE DRUG COSTS	1,106,253	759,603	3.12
3.13	73.00	DRUGS CHARGED TO PATIENTS	CARLE PHARMACISTS	178,671	128,928	3.13
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CARLE	1	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			20,783,198	15,984,620	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

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

6.00	B		0.00	CARLE HEALTH SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1316

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

Worksheet A-8-1

Date/Time Prepared:
7/7/2021 12:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-2,204,919	0		1.00
2.00	3,159,909	9		2.00
3.00	0	0		3.00
3.01	420,062	0		3.01
3.02	0	0		3.02
3.03	8,701	0		3.03
3.04	38,858	0		3.04
3.05	-279,802	0		3.05
3.06	309,325	0		3.06
3.07	1,681,794	0		3.07
3.08	1,146,177	0		3.08
3.09	122,079	0		3.09
3.12	346,650	0		3.12
3.13	49,743	0		3.13
4.00	1	0		4.00
5.00	4,798,578			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1316

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

Worksheet A-8-2

Date/Time Prepared:
7/7/2021 12:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. B	12,236	0	12,236	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	573,998	573,998	0	0	0	3.00
4.00	91.00	EMERGENCY	1,508,422	1,239,659	268,763	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	565,420	565,420	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,660,076	2,379,077	280,999		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	DR. B	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	DR. B	0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	573,998		3.00
4.00	91.00	EMERGENCY	0	0	0	1,239,659		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	565,420		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,379,077		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,444,619	4,444,619			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	829,844		829,844		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-279,801	0	0	-279,801	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,263,825	323,778	60,452	0	17,648,055
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,117,572	1,540,849	287,686	0	4,946,107
8.00	00800	LAUNDRY & LINEN SERVICE	80,380	6,819	1,273	0	88,472
9.00	00900	HOUSEKEEPING	404,030	93,130	17,388	0	514,548
10.00	01000	DIETARY	324,328	124,321	23,212	0	471,861
11.00	01100	CAFETERIA	0	29,675	5,541	0	35,216
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,516,555	109,104	20,371	0	1,646,030
14.00	01400	CENTRAL SERVICES & SUPPLY	229,377	0	0	0	229,377
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	309,325	55,878	10,433	0	375,636
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,566,242	789,871	147,475	0	2,503,588
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	752,302	436,229	81,447	0	1,269,978
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,946,748	214,673	40,081	0	2,201,502
60.00	06000	LABORATORY	2,754,964	110,936	20,713	0	2,886,613
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	641,056	56,699	10,586	0	708,341
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,118	0	0	0	26,118
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,876	0	0	0	2,876
73.00	07300	DRUGS CHARGED TO PATIENTS	1,415,443	3,662	684	0	1,419,789
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	28,052,864	298,396	55,713	0	28,406,973
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,148,063	250,599	46,789	0	2,445,451
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,546,730	4,444,619	829,844	0	67,826,531
NONREIMBURSABLE COST CENTERS							
192.01	19201	RETAIL PHARMACY	2,711,382	0	0	0	2,711,382
193.01	19301	MATTOON CLINIC	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	-279,801	-279,801
202.00		TOTAL (sum lines 118 through 201)	70,258,112	4,444,619	829,844	-279,801	70,258,112

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,648,055					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,650,397	0	6,596,504			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,521	0	17,435	135,428		8.00
9.00	00900	HOUSEKEEPING	171,692	0	238,115	0	924,355	9.00
10.00	01000	DIETARY	157,449	0	317,863	0	46,337	10.00
11.00	01100	CAFETERIA	11,751	0	75,874	0	11,061	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	549,241	0	278,957	0	40,665	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	76,538	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	125,341	0	142,869	0	20,827	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	835,387	0	2,019,536	135,428	294,397	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	423,761	0	1,115,345	0	162,590	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,588	0	548,875	0	80,012	54.00
60.00	06000	LABORATORY	963,193	0	283,639	0	41,348	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	236,356	0	144,967	0	21,133	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,715	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	960	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	473,750	0	9,363	0	1,365	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,478,704	0	762,936	0	111,217	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	815,988	0	640,730	0	93,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,743,332	0	6,596,504	135,428	924,355	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	904,723	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,648,055	0	6,596,504	135,428	924,355	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	993,510					10.00
11.00	01100	CAFETERIA	0	133,902				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,878	0	2,518,771		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	305,915	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	993,510	31,672	0	1,081,685	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,600	0	259,571	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,666	0	0	0	54.00
60.00	06000	LABORATORY	0	20,853	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	11,015	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	220,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	85,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	739	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	34,479	0	1,177,515	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	993,510	133,902	0	2,518,771	305,915	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	993,510	133,902	0	2,518,771	305,915	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	664,673				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	170,531	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	56,711	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	134,838	0	0	0	54.00
60.00	06000	LABORATORY	0	95,180	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	41,641	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	165,772	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	664,673	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	664,673	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	8,065,734	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,295,556	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,723,481	0	54.00
60.00	06000	LABORATORY	0	0	0	4,290,826	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	1,163,453	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	255,506	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	89,078	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,905,006	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	38,759,830	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	5,373,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	66,921,808	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	3,616,105	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-279,801	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	70,258,112	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		8,065,734	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		66,921,808	
NONREIMBURSABLE COST CENTERS			
192.01	19201	RETAIL PHARMACY	192.01
193.01	19301	MATTOON CLINIC	193.01
194.00	07950	FOUNDATION	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		70,258,112	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1316

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	323,778	60,452	384,230	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,540,849	287,686	1,828,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,819	1,273	8,092	8.00
9.00	00900	HOUSEKEEPING	0	93,130	17,388	110,518	9.00
10.00	01000	DIETARY	0	124,321	23,212	147,533	10.00
11.00	01100	CAFETERIA	0	29,675	5,541	35,216	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	109,104	20,371	129,475	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,878	10,433	66,311	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	789,871	147,475	937,346	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	436,229	81,447	517,676	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	214,673	40,081	254,754	54.00
60.00	06000	LABORATORY	0	110,936	20,713	131,649	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	56,699	10,586	67,285	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,662	684	4,346	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	298,396	55,713	354,109	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	250,599	46,789	297,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,444,619	829,844	5,274,463	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	RETAIL PHARMACY	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,444,619	829,844	5,274,463	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1316

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	384,230					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	35,933	0	1,864,468			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	643	0	4,928	13,663		8.00
9.00	00900	HOUSEKEEPING	3,738	0	67,302	0	181,558	9.00
10.00	01000	DIETARY	3,428	0	89,842	0	9,101	10.00
11.00	01100	CAFETERIA	256	0	21,445	0	2,172	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	11,958	0	78,846	0	7,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,666	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,729	0	40,381	0	4,091	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,189	0	570,812	13,663	57,825	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,226	0	315,247	0	31,935	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,994	0	155,137	0	15,716	54.00
60.00	06000	LABORATORY	20,971	0	80,169	0	8,121	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	5,146	0	40,974	0	4,151	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	190	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,315	0	2,646	0	268	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	206,363	0	215,640	0	21,845	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	17,766	0	181,099	0	18,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	364,532	0	1,864,468	13,663	181,558	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	19,698	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	384,230	0	1,864,468	13,663	181,558	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	249,904					10.00
11.00	01100	CAFETERIA	0	59,089				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,711	0	229,977		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,666	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	249,904	13,977	0	98,763	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,354	0	23,700	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,444	0	0	0	54.00
60.00	06000	LABORATORY	0	9,202	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	4,861	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	326	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,214	0	107,514	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	249,904	59,089	0	229,977	1,666	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	249,904	59,089	0	229,977	1,666	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	113,512				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	29,124	0			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,685	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,027	0			54.00
60.00	06000	LABORATORY	0	16,255	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
66.00	06600	PHYSICAL THERAPY	0	7,111	0			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0			90.00
91.00	09100	EMERGENCY	0	28,310	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	113,512	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0			192.01
193.01	19301	MATTOON CLINIC	0	0	0			193.01
194.00	07950	FOUNDATION	0	0	0			194.00
200.00		Cross Foot Adjustments				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	113,512	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,989,603	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				910,823	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				475,072	0	54.00
60.00	06000	LABORATORY				266,367	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
66.00	06600	PHYSICAL THERAPY				129,528	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				1,392	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				485	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				17,901	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				797,957	0	88.00
90.00	09000	CLINIC				0	0	90.00
91.00	09100	EMERGENCY				665,637	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,254,765	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY				19,698	0	192.01
193.01	19301	MATTOON CLINIC				0	0	193.01
194.00	07950	FOUNDATION				0	0	194.00
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	0	0	5,274,463	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		1,989,603	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		5,254,765	
NONREIMBURSABLE COST CENTERS			
192.01	19201	RETAIL PHARMACY	192.01
193.01	19301	MATTOON CLINIC	193.01
194.00	07950	FOUNDATION	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		5,274,463	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

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

Worksheet B-1

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,394					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		70,394				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	19,040,176			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,128	5,128	3,170,069	-17,648,055	52,889,858	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	24,404	24,404	635,732	0	4,946,107	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108	108	0	0	88,472	8.00
9.00	00900	HOUSEKEEPING	1,475	1,475	275,366	0	514,548	9.00
10.00	01000	DIETARY	1,969	1,969	162,431	0	471,861	10.00
11.00	01100	CAFETERIA	470	470	0	0	35,216	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,728	1,728	292,212	0	1,646,030	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	229,377	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	885	885	0	0	375,636	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,510	12,510	1,156,277	0	2,503,588	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,909	6,909	444,972	0	1,269,978	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,400	3,400	961,266	0	2,201,502	54.00
60.00	06000	LABORATORY	1,757	1,757	629,198	0	2,886,613	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	898	898	436,189	0	708,341	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58	58	40,365	0	1,419,789	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,726	4,726	9,530,327	0	28,406,973	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,969	3,969	1,305,772	0	2,445,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,394	70,394	19,040,176	-17,648,055	50,178,476	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	2,711,382	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,444,619	829,844	-279,801		17,648,055	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	63.139174	11.788562	0.000000		0.333676	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		384,230	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007265	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: 14-1316

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

Worksheet B-1

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	40,862				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108	100			8.00
9.00	00900	HOUSEKEEPING	0	1,475	0	39,279		9.00
10.00	01000	DIETARY	0	1,969	0	1,969	100	10.00
11.00	01100	CAFETERIA	0	470	0	470	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,728	0	1,728	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	885	0	885	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	12,510	100	12,510	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,909	0	6,909	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,400	0	3,400	0	54.00
60.00	06000	LABORATORY	0	1,757	0	1,757	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	898	0	898	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58	0	58	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	4,726	0	4,726	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,969	0	3,969	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	40,862	100	39,279	100	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	6,596,504	135,428	924,355	993,510	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	161.433704	1,354.280000	23.533058	9,935.100000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,864,468	13,663	181,558	249,904	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	45.628408	136.630000	4.622266	2,499.040000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

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

Worksheet B-1

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	145,928					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	4,226	0	80,375			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	130,941		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,517	0	34,517	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,283	0	8,283	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,792	0	0	0	0	54.00
60.00	06000	LABORATORY	22,726	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	12,004	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	94,455	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,486	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	805	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	37,575	0	37,575	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,928	0	80,375	130,941	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	133,902	0	2,518,771	305,915	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.917589	0.000000	31.337742	2.336281	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,089	0	229,977	1,666	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.404919	0.000000	2.861300	0.012723	0.000000	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: 14-1316

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

Worksheet B-1

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,380					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,150	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	715	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,700	0	0	0	0	54.00
60.00	06000	LABORATORY	1,200	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	525	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,090	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,380	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	0	0	0	193.01
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	664,673	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	79.316587	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,512	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.545585	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1316

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

Worksheet B-1

Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	RETAIL PHARMACY	0	0	192.01
193.01	19301	MATTOON CLINIC	0	0	193.01
194.00	07950	FOUNDATION	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,065,734		8,065,734	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,295,556		3,295,556	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,723,481		3,723,481	0
60.00	06000	LABORATORY	4,290,826		4,290,826	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
66.00	06600	PHYSICAL THERAPY	1,163,453	0	1,163,453	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	255,506		255,506	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,078		89,078	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,905,006		1,905,006	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,759,830		38,759,830	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	5,373,338		5,373,338	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,457,412		3,457,412	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
200.00		Subtotal (see instructions)	70,379,220	0	70,379,220	0
201.00		Less Observation Beds	3,457,412		3,457,412	0
202.00		Total (see instructions)	66,921,808	0	66,921,808	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

					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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,230,602		3,230,602				30.00	
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	112,985	1,943,176	2,056,161	1.602771	0.000000	50.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,286	19,821,502	20,803,788	0.178981	0.000000	54.00		
60.00	06000	LABORATORY	1,462,374	23,209,096	24,671,470	0.173919	0.000000	60.00		
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30		
66.00	06600	PHYSICAL THERAPY	202,070	1,181,428	1,383,498	0.840950	0.000000	66.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	320,213	679,069	999,282	0.255690	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,391	38,391	2.320283	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	1,288,375	5,458,893	6,747,268	0.282337	0.000000	73.00		
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98		
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99		
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	44,041,340	44,041,340			88.00		
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00		
91.00	09100	EMERGENCY	496,840	14,638,496	15,135,336	0.355019	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	297,462	3,853,522	4,150,984	0.832914	0.000000	92.00		
	OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0			99.10		
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20		
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30		
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40		
200.00		Subtotal (see instructions)	8,393,207	114,864,913	123,258,120			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	8,393,207	114,864,913	123,258,120			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				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
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,065,734		8,065,734	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,295,556		3,295,556	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,723,481		3,723,481	0
60.00	06000	LABORATORY	4,290,826		4,290,826	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
66.00	06600	PHYSICAL THERAPY	1,163,453	0	1,163,453	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	255,506		255,506	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,078		89,078	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,905,006		1,905,006	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,759,830		38,759,830	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	5,373,338		5,373,338	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
200.00		Subtotal (see instructions)	66,921,808	0	66,921,808	0
201.00		Less Observation Beds	0		0	0
202.00		Total (see instructions)	66,921,808	0	66,921,808	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

					Title XIX	Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/7/2021 12:52 pm

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	910,823	2,056,161	0.442973	31,878	14,121
54.00	05400	RADIOLOGY-DIAGNOSTIC	475,072	20,803,788	0.022836	444,005	10,139
60.00	06000	LABORATORY	266,367	24,671,470	0.010797	549,703	5,935
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
66.00	06600	PHYSICAL THERAPY	129,528	1,383,498	0.093624	17,840	1,670
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,392	999,282	0.001393	115,186	160
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	485	38,391	0.012633	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	17,901	6,747,268	0.002653	413,075	1,096
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	797,957	44,041,340	0.018118	0	0
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	665,637	15,135,336	0.043979	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	852,854	4,150,984	0.205458	140,620	28,892
200.00		Total (lines 50 through 199)	4,118,016	120,027,518		1,712,307	62,013

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1316

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

Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
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
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			Title XVIII		Hospital	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	2,056,161	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,803,788	0.000000
60.00	06000	LABORATORY	0	0	0	24,671,470	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,383,498	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	999,282	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,391	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,747,268	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	44,041,340	0.000000
90.00	09000	CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	15,135,336	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,150,984	0.000000
200.00		Total (lines 50 through 199)	0	0	0	120,027,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

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	31,878	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	444,005	0	0	0
60.00	06000	LABORATORY	0.000000	549,703	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	17,840	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	115,186	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	413,075	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	140,620	0	0	0
200.00		Total (lines 50 through 199)		1,712,307	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
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			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	1.602771	0	322,057	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178981	0	4,631,011	0	0	54.00
60.00	06000	LABORATORY	0.173919	0	5,697,282	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0.840950	0	237,455	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.255690	0	158,772	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2.320283	0	8,416	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282337	0	1,999,747	1,512	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.355019	0	3,697,940	1,575	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.832914	0	959,341	0	0	92.00
200.00		Subtotal (see instructions)		0	17,712,021	3,087	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	17,712,021	3,087	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/7/2021 12:52 pm

				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	516,184	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,863	0		54.00
60.00	06000	LABORATORY	990,866	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
66.00	06600	PHYSICAL THERAPY	199,688	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,596	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,528	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	564,603	427		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,312,839	559		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	799,049	0		92.00
200.00		Subtotal (see instructions)	5,272,216	986		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,272,216	986		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1316

Period:

Worksheet D

Component CCN: 14-Z316

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/7/2021 12:52 pm

				Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1.602771	0	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178981	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.173919	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30	
66.00	06600	PHYSICAL THERAPY	0.840950	0	0	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.255690	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2.320283	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282337	0	0	0	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.355019	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.832914	0	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1316

Period:

Worksheet D

Component CCN: 14-Z316

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/7/2021 12:52 pm

			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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				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
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: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	1,989,603	0	1,989,603	1,760	1,130.46	30.00
200.00	Total (lines 30 through 199)	1,989,603		1,989,603	1,760		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	13	14,696				30.00
200.00	Total (lines 30 through 199)	13	14,696				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			Title XIX		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	910,823	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	475,072	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	266,367	0	0.000000	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
66.00	06600	PHYSICAL THERAPY	129,528	0	0.000000	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,392	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	485	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,901	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	797,957	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	665,637	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,265,162	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1316		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/7/2021 12:52 pm	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	1,760	0.00	13	30.00		
200.00		Total (lines 30 through 199)		0	1,760		13	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	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1316

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

Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description			Title XIX		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	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1316

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

Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Title XIX		Hospital		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	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Title XIX		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	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
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
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/7/2021 12:52 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,351	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,760	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)		887	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		267	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		324	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)		375	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)		267	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		117.40	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.40	20.00	
21.00	Total general inpatient routine service cost (see instructions)		8,065,734	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)		38,038	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)		1,095,459	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,970,275	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,970,275	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)		3,960.38	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,485,143	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)		1,485,143	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1316

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

Worksheet D-1

Date/Time Prepared:
7/7/2021 12:52 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					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)					504,370 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,989,513 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)					1,057,421 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)					1,057,421 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)					873 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,960.38 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,457,412 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1316

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

Worksheet D-1

Date/Time Prepared:
7/7/2021 12:52 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,989,603	8,065,734	0.246674	3,457,412	852,854	90.00
91.00	Nursing School cost	0	8,065,734	0.000000	3,457,412	0	91.00
92.00	Allied health cost	0	8,065,734	0.000000	3,457,412	0	92.00
93.00	All other Medical Education	0	8,065,734	0.000000	3,457,412	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/7/2021 12:52 pm	
Cost Center Description		Title XVIII	Hospital	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		1,078,130		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.602771	31,878	51,093	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178981	444,005	79,468	54.00
60.00	06000 LABORATORY	0.173919	549,703	95,604	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.840950	17,840	15,003	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.255690	115,186	29,452	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2.320283	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.282337	413,075	116,626	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.355019	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.832914	140,620	117,124	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,712,307	504,370	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)		1,712,307		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1316 Component CCN: 14-Z316	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/7/2021 12:52 pm	
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		153,400		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.602771	1,300	2,084	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178981	23,475	4,202	54.00
60.00	06000 LABORATORY	0.173919	93,728	16,301	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.840950	87,910	73,928	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.255690	29,329	7,499	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2.320283	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.282337	395,879	111,771	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.355019	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.832914	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		631,621	215,785	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)		631,621		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/7/2021 12:52 pm
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,273,202	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)		5,273,202	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,325,934	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)		18,232	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,316,844	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,990,858	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,990,858	30.00
31.00	Primary payer payments		2,426	31.00
32.00	Subtotal (line 30 minus line 31)		2,988,432	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)		573,414	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		372,719	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		255,110	36.00
37.00	Subtotal (see instructions)		3,361,151	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)		3,361,151	40.00
40.01	Sequestration adjustment (see instructions)		22,184	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,722,314	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)		616,653	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: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/7/2021 12:52 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,846,562		3,192,222	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	11/18/2020	206,451	11/18/2020	469,908	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)		-206,451		-469,908	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)		1,640,111		2,722,314	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		230,314		616,653	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,870,425		3,338,967	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: 14-1316

Period:

Worksheet E-1

Component CCN: 14-Z316

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/7/2021 12:52 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,132,927		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,132,927		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		137,880		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,270,807		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: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/7/2021 12:52 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days 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: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2	
		Component CCN: 14-Z316		Date/Time Prepared: 7/7/2021 12:52 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,067,995	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)		217,943	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		267	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)		1,285,938	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,285,938	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)		1,285,938	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		6,688	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,279,250	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)		1,279,250	0	19.00
19.01	Sequestration adjustment (see instructions)		8,443	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		1,132,927	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)		137,880	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: 14-1316	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/7/2021 12:52 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,989,513	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)		1,989,513	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,009,408	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)		2,009,408	19.00
20.00	Deductibles (exclude professional component)		142,164	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,867,244	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,867,244	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		24,012	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,608	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,214	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,882,852	28.00
29.00	LOSS ON SALE OF ASSETS		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)		1,882,852	30.00
30.01	Sequestration adjustment (see instructions)		12,427	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		1,640,111	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)		230,314	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: 14-1316

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

Worksheet G

Date/Time Prepared:
7/7/2021 12:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-132,377	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,070,290	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,322,355	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	298,899	0	0	0	8.00
9.00	Other current assets	8,930	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)	2,923,387	0	0	0	11.00
FIXED ASSETS						
12.00	Land	110,211	0	0	0	12.00
13.00	Land improvements	1,192,318	0	0	0	13.00
14.00	Accumulated depreciation	-589,145	0	0	0	14.00
15.00	Buildings	12,947,452	0	0	0	15.00
16.00	Accumulated depreciation	-6,046,407	0	0	0	16.00
17.00	Leasehold improvements	1,737,515	0	0	0	17.00
18.00	Accumulated depreciation	-1,728,770	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	129,364	0	0	0	21.00
22.00	Accumulated depreciation	-93,639	0	0	0	22.00
23.00	Major movable equipment	12,252,806	0	0	0	23.00
24.00	Accumulated depreciation	-7,581,492	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,330,213	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,743,377	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	4,444,690	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,188,067	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,441,667	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	768,505	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,796,113	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,498,100	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,062,718	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,026,494	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	245,902	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,272,396	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,335,114	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,106,553				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)	10,106,553	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,441,667	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1316

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

Worksheet G-1

Date/Time Prepared:
7/7/2021 12:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,972,614				2.00
3.00	Total (sum of line 1 and line 2)		-1,972,614		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,972,614		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)		-1,972,614		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1316

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/7/2021 12:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,348,356		3,348,356	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,348,356		3,348,356	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)	3,348,356		3,348,356	17.00
18.00	Ancillary services	5,333,816	71,615,496	76,949,312	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	52,946,374	52,946,374	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	340B AND PROFEES	329,777	15,630,245	15,960,022	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,011,949	140,192,115	149,204,064	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		69,305,013		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	INCOME TAXES	5,300			31.00
32.00	BAD DEBTS	2,815,563			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)		2,820,863		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)		72,125,876		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1316

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

Worksheet G-3

Date/Time Prepared:
7/7/2021 12:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	149,204,064	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,658,335	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,545,729	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,125,876	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,580,147	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRUST INCOME	0	24.00
24.01	MISCELLANEOUS INCOME	235,480	24.01
24.02	PATIENT BILLING	10,148	24.02
24.03	GRANTS	181,625	24.03
24.04	RESTRICTED REVENUE	7,500	24.04
24.05	UNRESTRICTED REVENUE	172,780	24.05
24.06	BOND PROCEED INCOME	0	24.06
24.07	OTHER	0	24.07
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	607,533	25.00
26.00	Total (line 5 plus line 25)	-1,972,614	26.00
27.00	LOSS ON DISPOSAL	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,972,614	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1316

Period:

Worksheet M-1

Component CCN: 14-3448

From 01/01/2020

Date/Time Prepared:

To 12/31/2020

7/7/2021 12:52 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	9,811,460	9,811,460	0	9,811,460	1.00
2.00	Physician Assistant	1,057,100	0	1,057,100	0	1,057,100	2.00
3.00	Nurse Practitioner	3,164,181	0	3,164,181	0	3,164,181	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,903,285	0	2,903,285	0	2,903,285	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	2,249,095	0	2,249,095	0	2,249,095	9.00
10.00	Subtotal (sum of lines 1 through 9)	9,373,661	9,811,460	19,185,121	0	19,185,121	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,614,129	1,614,129	0	1,614,129	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,614,129	1,614,129	0	1,614,129	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	9,373,661	11,425,589	20,799,250	0	20,799,250	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	1,973,599	1,973,599	0	1,973,599	29.00
30.00	Administrative Costs	711,125	5,210,332	5,921,457	-730,533	5,190,924	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	711,125	7,183,931	7,895,056	-730,533	7,164,523	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	10,084,786	18,609,520	28,694,306	-730,533	27,963,773	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1316

Period:

Worksheet M-1

Component CCN: 14-3448

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/7/2021 12:52 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	9,811,460	1.00
2.00	Physician Assistant	0	1,057,100	2.00
3.00	Nurse Practitioner	0	3,164,181	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	2,903,285	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	2,249,095	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	19,185,121	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	1,614,129	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,614,129	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	20,799,250	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,973,599	29.00
30.00	Administrative Costs	89,091	5,280,015	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	89,091	7,253,614	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	89,091	28,052,864	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1316

Period:

Worksheet M-2

Component CCN: 14-3448

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/7/2021 12:52 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	21.01	100,719	4,200	88,242	1.00
2.00	Physician Assistant	6.69	11,321	2,100	14,049	2.00
3.00	Nurse Practitioner	21.69	36,717	2,100	45,549	3.00
4.00	Subtotal (sum of lines 1 through 3)	49.39	148,757		147,840	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)	49.39	148,757		148,757	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)				20,799,250	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				20,799,250	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				7,253,614	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				10,706,966	15.00
16.00	Total overhead (sum of lines 14 and 15)				17,960,580	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				17,960,580	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				17,960,580	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				38,759,830	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/7/2021 12:52 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			38,759,830	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,883,537	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			34,876,293	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			148,757	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)			148,757	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			234.45	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			234.45	234.45	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	18,432	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	4,321,382	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	4,321,382	16.00
16.01	Total program charges (see instructions)(from contractor's records)				0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				3,084,038	16.04
16.05	Total program cost (see instructions)			0	3,084,038	16.05
17.00	Primary payer amounts				2,003	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				466,335	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				850,031	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				3,082,035	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				678,972	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				3,761,007	22.00
23.00	Allowable bad debts (see instructions)				418,712	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				272,163	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				229,524	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)				4,033,170	26.00
26.01	Sequestration adjustment (see instructions)				26,619	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				2,934,921	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)				1,071,630	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: 14-1316 Component CCN: 14-3448	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/7/2021 12:52 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		19,185,121	19,185,121	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.021400	0.042530	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		410,562	815,943	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		670,201	187,270	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,080,763	1,003,213	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		20,799,250	20,799,250	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		17,960,580	17,960,580	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.051962	0.048233	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		933,268	866,293	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,014,031	1,869,506	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		5,443	7,681	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		370.02	243.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		747	1,654	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		276,405	402,567	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)			3,883,537	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)			678,972	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1316 Component CCN: 14-3448	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/7/2021 12:52 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,703,020	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		11/18/2020	231,901	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		231,901	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,934,921	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		1,071,630	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,006,551	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00