

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND Provider CCN:14-1329 Period: From 07/01/2019 To 06/30/2020 Worksheet S Parts I-III Date/Time Prepared: 11/24/2020 3:49 pm

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date:11/24/2020 Time: 3:49 pm
 2. ☐ Manually prepared cost report
 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only 5. ☐ Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. ☐ Initial Report for this Provider CCN 12. ☐ If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. ☐ Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE 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 MORRISON COMMUNITY HOSPITAL (14-1329) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CAMI MEGLI
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 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	9,729	227,050	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	285,883	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		95,720		0	10.00
200.00	Total	0	295,612	322,770	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 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 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.

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 3:49 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street:303 JACKSON		PO Box:						1.00	
2.00	City: MORRISON		State: IL		Zip Code:61270		County: WHITESIDE		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O
4.00	Subprovider - IPF									3.00
5.00	Subprovider - IRF									4.00
6.00	Subprovider - (Other)									5.00
7.00	Swing Beds - SNF		MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N
8.00	Swing Beds - NF									6.00
9.00	Hospital-Based SNF									7.00
10.00	Hospital-Based NF									8.00
11.00	Hospital-Based OLTC									9.00
12.00	Hospital-Based HHA									10.00
13.00	Separately Certified ASC									11.00
14.00	Hospital-Based Hospice									12.00
15.00	Hospital-Based Health Clinic - RHC		MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O
16.00	Hospital-Based Health Clinic - FQHC									13.00
17.00	Hospital-Based (CMHC) I									14.00
18.00	Renal Dialysis									15.00
19.00	Other									16.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2019	06/30/2020		20.00	
21.00	Type of Control (see instructions)					11			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
			1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 3:49 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural Status	Date of Geographic Reclassification		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.								56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

	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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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
<u>Inpatient Psychiatric Facility PPS</u>							
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)				N 0	71.00	
<u>Inpatient Rehabilitation Facility PPS</u>							
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	

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
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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.			N	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	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?			Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y	106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y	108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	109.00
			N	N	Y
			N	N	N

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 3:49 pm	
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	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			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	146,580	0		118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312N 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			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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		
				Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 3:49 pm		
		1.00		2.00		
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)				140.00	
1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:		Contractor's Name:		141.00	
142.00	Street:		PO Box:		142.00	
143.00	City:		State:		143.00	
				Zip Code:		
				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.				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		
		1.00		2.00		
		Title V		Title XIX		
		3.00		4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name		County		
		0		1.00		
		State		Zip Code		
		2.00		3.00		
		CBSA		FTE/Campus		
		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.				N	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:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 3:49 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:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 3:49 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
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
			Y/N 1.00	Type 2.00
			Date 2.00	V/I 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.			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 Y/N 1.00	Part B Date 2.00
			Y/N 1.00	Date 2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N	N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/05/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N	N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N	N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 3:49 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	21.00
			1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y		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.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	JILL	NELSON	41.00
42.00	Enter the employer/company name of the cost report preparer	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-455-9706	JILL.NELSON@RSMUS.COM	43.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 3:49 pm
		3.00			
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 3:49 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	25	9,150	2,304.00	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)		25	9,150	2,304.00	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)		25	9,150	2,304.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 3:49 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)	34	0	96			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,638	0	2,385			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	427			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,672	0	2,908			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)	1,672	0	2,908	0.00	119.80	14.00
15.00	CAH visits	1,804	203	2,977			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,916	666	19,985	0.00	23.90	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	143.70	27.00
28.00	Observation Bed Days		8	109			28.00
29.00	Ambulance Trips	205					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:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 3:49 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	12	3	29	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	12	3	29	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 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		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1329 Component CCN:14-3981		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/24/2020 3:49 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	303 NORTH JACKSON STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MORRISON		IL	61270
		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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		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.)	yes or N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	18:00	08:00	18:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	WHITESIDE			
		Tuesday		Wednesday	Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	18:00	08:00	18:00	08:00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1329	Period: From 07/01/2019	Worksheet S-8	
		Component CCN:14-3981	To 06/30/2020	Date/Time Prepared: 11/24/2020 3:49 pm	
		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	18:00	08:00	18:00
					11.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/24/2020 3:49 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)	0.724389		1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	3,136,558		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	4,692,469		6.00	
7.00	Medicaid cost (line 1 times line 6)	3,399,173		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)	262,615		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	3,856,075		18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 16 and 17)	1262,615		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)	15,183	14,908	30,091	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,998	14,908	25,906	21.00
22.00	Payments received from patients for amounts previously written off as charity care	8,375	6,090	14,465	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,623	8,818	11,441	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)	671,977		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	107,946		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	166,072		27.01	
28.00	Non-Medicare bad debt expense (see instructions)	505,905		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	424,598		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	436,039		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	698,654		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1329

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

Worksheet A

Date/Time Prepared:
11/24/2020 3:49 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		465,949	465,949	-89,014	376,935	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		167,805	167,805	166,923	334,728	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,355,401	2,355,401	-283,646	2,071,755	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	57,996	-13,285	44,711	0	44,711	5.01
5.02	00591	PERSONNEL	70,277	8,149	78,426	0	78,426	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	323,579	124,320	447,899	0	447,899	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	524,384	1,026,089	1,550,473	52,485	1,602,958	5.05
7.00	00700	OPERATION OF PLANT	189,303	357,285	546,588	0	546,588	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,333	28,333	0	28,333	8.00
9.00	00900	HOUSEKEEPING	152,190	25,466	177,656	0	177,656	9.00
10.00	01000	DIETARY	217,111	86,148	303,259	0	303,259	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	156,516	13,080	169,596	0	169,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,697	42,398	61,095	0	61,095	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	258,528	96,484	355,012	0	355,012	16.00
17.00	01700	SOCIAL SERVICE	87,637	772	88,409	0	88,409	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,618,820	127,831	1,746,651	-539	1,746,112	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	447,398	130,655	578,053	8,110	586,163	50.00
53.00	05300	ANESTHESIOLOGY	89,981	199,367	289,348	-2,582	286,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	332,817	217,063	549,880	0	549,880	54.00
60.00	06000	LABORATORY	467,765	455,072	922,837	2,380	925,217	60.00
64.00	06400	INTRAVENOUS THERAPY	0	38,739	38,739	10,502	49,241	64.00
65.00	06500	RESPIRATORY THERAPY	56,013	55,089	111,102	-51,582	59,520	65.00
66.00	06600	PHYSICAL THERAPY	277,934	3,094	281,028	0	281,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,251	532	209,783	0	209,783	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,125	12,125	0	12,125	68.00
69.00	06900	ELECTROCARDIOLOGY	4,129	16,775	20,904	0	20,904	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,400	34,400	52,696	87,096	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	447,244	447,244	0	447,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,662	452,998	613,660	0	613,660	73.00
76.00	03950	NEUROLOGY	343	27,000	27,343	0	27,343	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,058,496	639,745	3,698,241	236,786	3,935,027	88.00
91.00	09100	EMERGENCY	468,792	1,730,349	2,199,141	-46,610	2,152,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	59,262	2,931	62,193	0	62,193	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	157,023	50,721	207,744	-10,634	197,110	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		50,052	50,052	-50,052	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,464,904	9,476,176	18,941,080	-4,777	18,936,303	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	4,777	4,777	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	9,464,904	9,476,176	18,941,080	0	18,941,080	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1329

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

Worksheet A

Date/Time Prepared:
11/24/2020 3:49 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	0	376,935	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,634	331,094	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-77,569	1,994,186	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	44,711	5.01
5.02	00591	PERSONNEL	0	78,426	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-16,651	431,248	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-12,115	1,590,843	5.05
7.00	00700	OPERATION OF PLANT	0	546,588	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,333	8.00
9.00	00900	HOUSEKEEPING	0	177,656	9.00
10.00	01000	DIETARY	-70,286	232,973	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	169,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	61,095	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,247	349,765	16.00
17.00	01700	SOCIAL SERVICE	0	88,409	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,746,112	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-83,435	502,728	50.00
53.00	05300	ANESTHESIOLOGY	-123,525	163,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,250	547,630	54.00
60.00	06000	LABORATORY	-15,013	910,204	60.00
64.00	06400	INTRAVENOUS THERAPY	0	49,241	64.00
65.00	06500	RESPIRATORY THERAPY	0	59,520	65.00
66.00	06600	PHYSICAL THERAPY	-5,840	275,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,783	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,125	68.00
69.00	06900	ELECTROCARDIOLOGY	-8,948	11,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	87,096	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	447,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,672	603,988	73.00
76.00	03950	NEUROLOGY	-27,000	343	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-116,979	3,818,048	88.00
91.00	09100	EMERGENCY	-343,412	1,809,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	0	62,193	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	197,110	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-921,576	18,014,727	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	4,777	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-921,576	18,019,504	200.00

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	33,991	1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	11,064	2.00
3.00	OPERATING ROOM	50.00	0	2,617	3.00
4.00	LABORATORY	60.00	0	2,380	4.00
	TOTALS		0	50,052	
B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,334	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,584	2.00
3.00	ADMINISTRATIVE & GENERAL	5.05	0	46,198	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	90,116	
C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	157,339	1.00
	TOTALS		0	157,339	
D - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	52,696	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	52,696	
E - RHC PHYSICIAN IN ER					
1.00	EMERGENCY	91.00	0	7,243	1.00
2.00	EMERGENCY	91.00	0	368	2.00
	TOTALS		0	7,611	
F - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	10,502	0	1.00
	TOTALS		10,502	0	
G - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	277,785	1.00
2.00	OPERATING ROOM	50.00	0	5,861	2.00
	TOTALS		0	283,646	
I - MARKETING RECLASS					
1.00	OTHER NON-REIMBURSABLE COST CENTERS	194.02	0	4,777	1.00
	TOTALS		0	4,777	
500.00	Grand Total: Increases		10,502	646,237	500.00

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	50,052	11	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
	TOTALS		0	50,052			
	B - INSURANCE						
1.00	ANESTHESIOLOGY	53.00	0	2,582	12	1.00	
2.00	EMERGENCY	91.00	0	43,144	12	2.00	
3.00	RURAL HEALTH CLINIC	88.00	0	33,756	0	3.00	
4.00	AMBULANCE SERVICES	95.00	0	10,634	0	4.00	
	TOTALS		0	90,116			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	157,339	9	1.00	
	TOTALS		0	157,339			
	D - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	539	0	1.00	
2.00	RESPIRATORY THERAPY	65.00	0	51,582	0	2.00	
3.00	EMERGENCY	91.00	0	575	0	3.00	
	TOTALS		0	52,696			
	E - RHC PHYSICIAN IN ER						
1.00	RURAL HEALTH CLINIC	88.00	0	7,243	0	1.00	
2.00	OPERATING ROOM	50.00	0	368	0	2.00	
	TOTALS		0	7,611			
	F - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	10,502	0	0	1.00	
	TOTALS		10,502	0			
	G - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	283,646	0	1.00	
2.00		0.00	0	0	0	2.00	
	TOTALS		0	283,646			
	I - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.05	0	4,777	0	1.00	
	TOTALS		0	4,777			
500.00	Grand Total: Decreases		10,502	646,237		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	214,162	0	0	0	0	1.00
2.00	Land Improvements	429,924	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,336,456	7,132,349	0	7,132,349	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	939,479	286,480	0	286,480	0	5.00
6.00	Movable Equipment	5,083,345	340,158	0	340,158	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,003,366	7,758,987	0	7,758,987	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,003,366	7,758,987	0	7,758,987	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	214,162	0				1.00
2.00	Land Improvements	429,924	0				2.00
3.00	Buildings and Fixtures	19,468,805	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,225,959	0				5.00
6.00	Movable Equipment	5,423,503	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	26,762,353	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	26,762,353	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/24/2020 3:49 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	465,949	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	167,805	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	633,754	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	465,949				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	167,805				2.00
3.00	Total (sum of lines 1-2)	0	633,754				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/24/2020 3:49 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	21,338,850	0	21,338,850	0.797346	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,423,503	0	5,423,503	0.202654	0	2.00
3.00	Total (sum of lines 1-2)	26,762,353	0	26,762,353	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	308,610	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	321,510	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	630,120	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	33,991	34,334	0	0	376,935	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,584	0	0	331,094	2.00
3.00	Total (sum of lines 1-2)	33,991	43,918	0	0	708,029	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1329

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 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)	A	-1,406		ADMINISTRATIVE & GENERAL	5.05	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	-705,549				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	0				0 12.00
13.00	Laundry and linen service		0			0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-58,296		DIETARY	10.00	0 14.00
15.00	Rental of quarters to employees and others		0			0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00	Sale of drugs to other than patients		0			0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-5,247		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00	Vending machines		0			0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-3,634		CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00	CATERING REVENUE	B	-11,990		DIETARY	10.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1329

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 3:49 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00	5.00
33.01	LAB OTHER REVENUE	B		-15,013	LABORATORY	60.00	0 33.01
33.02	REHAB MISC REV	B		-5,840	PHYSICAL THERAPY	66.00	0 33.02
33.03	OTHER REV -A&G	B		-816	ADMINISTRATIVE & GENERAL	5.05	0 33.03
33.04	NONALLOWABLE DUES	B		-6,271	ADMINISTRATIVE & GENERAL	5.05	0 33.04
33.05	PATIENT TELEPHONE - SALARIES	A		-3,622	ADMINISTRATIVE & GENERAL	5.05	0 33.05
33.06	PATIENT TELEPHONE - BENEFITS	A		-901	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.06
33.07	PHYSICIAN BILLING SALARIES	A		-16,651	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0 33.07
33.08	PHYSICIAN BILLING EMPLOYEE BENEFITS	A		-4,144	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.08
33.09	PHARMACY DRUG RETAIL 340B	A		-9,672	DRUGS CHARGED TO PATIENTS	73.00	0 33.09
33.10	ADVERTISING, MOVED TO A-6, PER NPR	A			ADMINISTRATIVE & GENERAL	5.05	0 33.10
33.11	SELF INSURANCE EXPENSE	A		-72,524	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.11
33.12	SELF INSURANCE EXPENSE	A			ANESTHESIOLOGY	53.00	0 33.12
33.13	SELF INSURANCE EXPENSE	A			RADIOLOGY-DIAGNOSTIC	54.00	0 33.13
33.14	SELF INSURANCE EXPENSE	A			LABORATORY	60.00	0 33.14
33.15	SELF INSURANCE EXPENSE	A			INTRAVENOUS THERAPY	64.00	0 33.15
33.16	SELF INSURANCE EXPENSE	A			RESPIRATORY THERAPY	65.00	0 33.16
33.17	SELF INSURANCE EXPENSE	A			PHYSICAL THERAPY	66.00	0 33.17
33.18	SELF INSURANCE EXPENSE	A			OCCUPATIONAL THERAPY	67.00	0 33.18
33.19	SELF INSURANCE EXPENSE	A			ELECTROCARDIOLOGY	69.00	0 33.19
33.20	SELF INSURANCE EXPENSE	A			MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0 33.20
33.21	SELF INSURANCE EXPENSE	A			IMPL. DEV. CHARGED TO PATIENTS	72.00	0 33.21
33.22	SELF INSURANCE EXPENSE	A			DRUGS CHARGED TO PATIENTS	73.00	0 33.22
33.24	SELF INSURANCE EXPENSE	A			EMERGENCY	91.00	0 33.24
33.25	SELF INSURANCE EXPENSE	A			WOUND CARE	93.00	0 33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-921,576			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-1329

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

Worksheet A-8-2

Date/Time Prepared:
11/24/2020 3:49 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	91.00	EMERGENCY	1,616,620	343,412	1,273,208	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	25,793	0	25,793	0	0	2.00
3.00	60.00	LABORATORY	15,000	0	15,000	0	0	3.00
4.00	91.00	EMERGENCY	19,903	0	19,903	0	0	4.00
5.00	50.00	OPERATING ROOM	5,905	5,905	0	0	0	5.00
6.00	50.00	OPERATING ROOM	77,530	77,530	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	2,250	2,250	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	8,948	8,948	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	116,979	116,979	0	0	0	9.00
10.00	76.00	NEUROLOGY	27,000	27,000	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	123,525	123,525	0	0	0	11.00
200.00			2,039,453	705,549	1,333,904		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	9.00
10.00	76.00	NEUROLOGY	0	0	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	343,412		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	5,905		5.00
6.00	50.00	OPERATING ROOM	0	0	0	77,530		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,250		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,948		8.00
9.00	88.00	RURAL HEALTH CLINIC	0	0	0	116,979		9.00
10.00	76.00	NEUROLOGY	0	0	0	27,000		10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	123,525		11.00
200.00			0	0	0	705,549		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE PROVIDER CCN:14-1329		Period: From 07/01/2019 To 06/30/2020	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 3:49 pm	
SPEECH PATHOLOGY		Cost		
		1.00		
PART I - GENERAL INFORMATION				
1.00	Total number of weeks worked (excluding aides) (see instructions)		32	1.00
2.00	Line 1 multiplied by 15 hours per week		480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		76	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.55	7.00
8.00	Optional travel expense rate per mile		0.56	8.00
		Supervisors	Therapists	Assistants
		1.00	2.00	3.00
				Aides
				4.00
				Trainees
				5.00
9.00	Total hours worked	0.00	72.00	0.00
10.00	AHSEA (see instructions)	96.70	77.36	58.02
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.68	38.68	29.01
12.00	Number of travel hours (provider site)	0	0	0
12.01	Number of travel hours (offsite)	0	0	0
13.00	Number of miles driven (provider site)	0	0	0
13.01	Number of miles driven (offsite)	0	0	0
1.00				
Part II - SALARY EQUIVALENCY COMPUTATION				
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		5,570	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		5,570	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		5,570	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.				
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		77.36	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		37,133	22.00
23.00	Total salary equivalency (see instructions)		37,133	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE				
Standard Travel Allowance				
24.00	Therapists (line 3 times column 2, line 11)		2,940	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		2,940	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		422	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		3,362	28.00
Optional Travel Allowance and Optional Travel Expense				
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		3,362	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE				
Standard Travel Expense				
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
Optional Travel Allowance and Optional Travel Expense				
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.				
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 3:49 pm	
		Speech Pathology		Cost			
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.36	58.02	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						37,133 57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,362 58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0 59.00
60.00	Overtime allowance (from column 5, line 56)						0 60.00
61.00	Equipment cost (see instructions)						0 61.00
62.00	Supplies (see instructions)						0 62.00
63.00	Total allowance (sum of lines 57-62)						40,495 63.00
64.00	Total cost of outside supplier services (from your records)						12,125 64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0 65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,940 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						422 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,362 100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						422 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 101.01
101.02	Line 34 = sum of lines 27 and 31						422 101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0 102.01
102.02	Line 35 = sum of lines 31 and 32						0 102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	376,935	376,935			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	331,094		331,094		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,994,186	0	1,994,186		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	44,711	11,215	16,389	72,315	5.01
5.02	00591	PERSONNEL	78,426	2,293	19,860	142	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	431,248	6,781	86,736	1,135	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,590,843	20,363	147,164	4,504	5.05
7.00	00700	OPERATION OF PLANT	546,588	69,334	53,496	567	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,333	8,829	0	0	8.00
9.00	00900	HOUSEKEEPING	177,656	3,685	43,008	284	9.00
10.00	01000	DIETARY	232,973	10,208	61,354	390	10.00
11.00	01100	CAFETERIA	0	3,931	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	169,596	4,077	44,230	497	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,095	3,447	5,284	16,102	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	349,765	8,776	73,058	0	16.00
17.00	01700	SOCIAL SERVICE	88,409	1,014	24,766	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,746,112	61,930	25,459	457,462	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	502,728	15,577	107,981	104,522	50.00
53.00	05300	ANESTHESIOLOGY	163,241	0	0	25,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,630	10,665	106,603	94,052	54.00
60.00	06000	LABORATORY	910,204	10,095	23,524	132,187	60.00
64.00	06400	INTRAVENOUS THERAPY	49,241	0	0	2,968	64.00
65.00	06500	RESPIRATORY THERAPY	59,520	0	1,099	15,829	65.00
66.00	06600	PHYSICAL THERAPY	275,188	17,300	0	78,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,783	3,281	0	59,133	67.00
68.00	06800	SPEECH PATHOLOGY	12,125	809	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,956	0	1,646	1,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,096	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	447,244	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,988	3,208	3,631	45,402	73.00
76.00	03950	NEUROLOGY	343	0	0	97	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,818,048	69,864	5,408	211,421	88.00
91.00	09100	EMERGENCY	1,809,119	8,750	3,039	129,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	62,193	2,035	0	16,747	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	197,110	18,692	13,562	44,374	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,014,727	376,159	331,094	1,994,186	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	776	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	4,777	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,019,504	376,935	331,094	1,994,186	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description			PERSONNEL	CASHIERING/ACCO UNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	100,721					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,491	530,175				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	5,657	0	1,804,972	1,804,972		5.05
7.00	00700	OPERATION OF PLANT	2,042	0	673,755	75,001	748,756	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	37,162	4,137	24,765	8.00
9.00	00900	HOUSEKEEPING	1,642	0	226,275	25,188	10,337	9.00
10.00	01000	DIETARY	2,342	0	307,267	34,204	28,632	10.00
11.00	01100	CAFETERIA	0	0	3,931	438	11,025	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	0	220,088	24,500	11,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202	0	86,130	9,588	9,668	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,789	0	434,577	48,376	24,616	16.00
17.00	01700	SOCIAL SERVICE	945	0	115,134	12,816	2,845	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,464	35,405	2,348,868	261,471	173,705	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,827	69,085	813,445	90,551	43,691	50.00
53.00	05300	ANESTHESIOLOGY	971	6,457	197,941	22,034	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,590	87,646	853,059	94,961	29,915	54.00
60.00	06000	LABORATORY	5,046	69,092	1,151,957	128,234	28,316	60.00
64.00	06400	INTRAVENOUS THERAPY	113	15,842	68,164	7,588	0	64.00
65.00	06500	RESPIRATORY THERAPY	604	4,591	81,643	9,088	0	65.00
66.00	06600	PHYSICAL THERAPY	2,998	24,091	399,360	44,456	48,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,257	13,908	288,362	32,100	9,203	67.00
68.00	06800	SPEECH PATHOLOGY	0	380	13,314	1,482	2,268	68.00
69.00	06900	ELECTROCARDIOLOGY	45	2,766	17,580	1,957	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,761	94,566	10,527	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,559	467,803	52,075	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,733	44,494	703,733	78,338	8,999	73.00
76.00	03950	NEUROLOGY	4	914	1,358	151	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	32,994	78,258	4,222,483	470,043	195,959	88.00
91.00	09100	EMERGENCY	4,944	35,149	2,005,087	223,202	24,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	639	1,321	83,006	9,240	5,708	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,694	13,456	292,931	32,608	52,429	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,721	530,175	18,013,951	1,804,354	746,581	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	776	86	2,175	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	4,777	532	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	100,721	530,175	18,019,504	1,804,972	748,756	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,064				8.00
9.00	00900	HOUSEKEEPING	0	261,800			9.00
10.00	01000	DIETARY	0	1,462	371,565		10.00
11.00	01100	CAFETERIA	0	0	218,699	234,093	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,658	0	4,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,637	0	1,605	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,858	0	14,822	16.00
17.00	01700	SOCIAL SERVICE	0	1,364	0	3,079	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,524	81,873	149,157	65,357	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,636	14,605	0	12,205	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,353	12,929	0	13,810	54.00
60.00	06000	LABORATORY	0	13,580	0	17,109	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	176	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,001	65.00
66.00	06600	PHYSICAL THERAPY	2,240	23,290	0	7,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,414	0	4,728	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,088	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,620	0	4,288	73.00
76.00	03950	NEUROLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,152	77,129	0	52,558	88.00
91.00	09100	EMERGENCY	16,926	11,779	0	20,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	0	1,471	0	2,023	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	233	0	0	6,773	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,064	260,757	367,856	234,093	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,043	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	3,709	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,064	261,800	371,565	234,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	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
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,628				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	528,249			16.00
17.00	01700	SOCIAL SERVICE	0	0	141,850		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	33,461	141,850	3,428,483	-24,433
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	58,562	76,440	0	1,142,340	0
53.00	05300	ANESTHESIOLOGY	0	11,359	0	232,104	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,128	0	1,092,155	0
60.00	06000	LABORATORY	0	65,298	0	1,404,494	0
64.00	06400	INTRAVENOUS THERAPY	0	14,972	0	91,272	24,433
65.00	06500	RESPIRATORY THERAPY	0	4,339	0	101,351	0
66.00	06600	PHYSICAL THERAPY	0	22,768	0	565,749	0
67.00	06700	OCCUPATIONAL THERAPY	0	13,144	0	362,092	0
68.00	06800	SPEECH PATHOLOGY	0	359	0	18,511	0
69.00	06900	ELECTROCARDIOLOGY	0	3,308	0	23,109	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,389	0	111,482	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,430	0	539,308	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,051	0	850,247	0
76.00	03950	NEUROLOGY	0	1,322	0	2,831	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	49,547	73,961	0	5,144,832	0
91.00	09100	EMERGENCY	3,519	42,554	0	2,391,328	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
93.00	04950	WOUND CARE	0	1,249	0	107,027	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	12,717	0	397,691	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,628	528,249	141,850	18,006,406	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
194.00	07950	OPHTH CLINIC	0	0	0	0	0
194.01	07951	RENTAL SPACE	0	0	0	4,080	0
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	9,018	0
200.00		Cross Foot Adjustments				0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	111,628	528,249	141,850	18,019,504	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 3:49 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
5.01	00560	PURCHASING RECEIVING AND STORES	5.01
5.02	00591	PERSONNEL	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	NEUROLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	WOUND CARE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OPHTH CLINIC	194.00
194.01	07951	RENTAL SPACE	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	11,215	0	11,215	0 5.01
5.02	00591	PERSONNEL	0	2,293	0	2,293	0 5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	6,781	784	7,565	0 5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	20,363	36,441	56,804	0 5.05
7.00	00700	OPERATION OF PLANT	0	69,334	1,728	71,062	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,829	0	8,829	0 8.00
9.00	00900	HOUSEKEEPING	0	3,685	0	3,685	0 9.00
10.00	01000	DIETARY	0	10,208	0	10,208	0 10.00
11.00	01100	CAFETERIA	0	3,931	0	3,931	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	4,077	0	4,077	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,447	0	3,447	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,776	189	8,965	0 16.00
17.00	01700	SOCIAL SERVICE	0	1,014	0	1,014	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	61,930	25,459	87,389	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,577	107,981	123,558	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,665	106,603	117,268	0 54.00
60.00	06000	LABORATORY	0	10,095	23,524	33,619	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,099	1,099	0 65.00
66.00	06600	PHYSICAL THERAPY	0	17,300	0	17,300	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,281	0	3,281	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	809	0	809	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,646	1,646	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,208	3,631	6,839	0 73.00
76.00	03950	NEUROLOGY	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	69,864	5,408	75,272	0 88.00
91.00	09100	EMERGENCY	0	8,750	3,039	11,789	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
93.00	04950	WOUND CARE	0	2,035	0	2,035	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	18,692	13,562	32,254	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	376,159	331,094	707,253	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0 194.00
194.01	07951	RENTAL SPACE	0	776	0	776	0 194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	376,935	331,094	708,029	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	11,215					5.01
5.02	00591	PERSONNEL	22	2,315				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	176	80	7,821			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	699	130	0	57,633		5.05
7.00	00700	OPERATION OF PLANT	88	47	0	2,395	73,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	132	2,434	8.00
9.00	00900	HOUSEKEEPING	44	38	0	804	1,016	9.00
10.00	01000	DIETARY	61	54	0	1,092	2,814	10.00
11.00	01100	CAFETERIA	0	0	0	14	1,084	11.00
13.00	01300	NURSING ADMINISTRATION	77	39	0	782	1,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,494	5	0	306	950	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64	0	1,544	2,419	16.00
17.00	01700	SOCIAL SERVICE	0	22	0	409	280	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	781	401	522	8,348	17,073	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,353	111	1,019	2,891	4,294	50.00
53.00	05300	ANESTHESIOLOGY	286	22	95	703	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	446	83	1,296	3,032	2,940	54.00
60.00	06000	LABORATORY	281	116	1,019	4,094	2,783	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3	234	242	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14	68	290	0	65.00
66.00	06600	PHYSICAL THERAPY	193	69	355	1,419	4,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	52	205	1,025	905	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	6	47	223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	41	62	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110	0	100	336	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	303	1,663	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198	40	656	2,501	884	73.00
76.00	03950	NEUROLOGY	0	0	13	5	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,007	756	1,154	15,015	19,260	88.00
91.00	09100	EMERGENCY	2,261	114	518	7,126	2,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	11	15	19	295	561	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	627	39	198	1,041	5,153	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,215	2,315	7,821	57,613	73,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	3	214	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	17	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,215	2,315	7,821	57,633	73,592	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,395				8.00
9.00	00900	HOUSEKEEPING	0	5,587			9.00
10.00	01000	DIETARY	0	31	14,260		10.00
11.00	01100	CAFETERIA	0	0	8,394	13,423	11.00
13.00	01300	NURSING ADMINISTRATION	0	35	0	246	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	99	0	92	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	125	0	850	16.00
17.00	01700	SOCIAL SERVICE	0	29	0	177	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,610	1,749	5,724	3,747	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,145	312	0	700	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751	276	0	792	54.00
60.00	06000	LABORATORY	0	290	0	981	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	115	65.00
66.00	06600	PHYSICAL THERAPY	386	497	0	458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	94	0	271	67.00
68.00	06800	SPEECH PATHOLOGY	0	23	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77	0	246	73.00
76.00	03950	NEUROLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	544	1,646	0	3,014	88.00
91.00	09100	EMERGENCY	2,919	251	0	1,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	0	31	0	116	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	40	0	0	388	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,395	5,565	14,118	13,423	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	22	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	142	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,395	5,587	14,260	13,423	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	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
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,393				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,967			16.00
17.00	01700	SOCIAL SERVICE	0	0	2,092		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	885	2,092	137,737	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,879	2,022	0	141,922	0 50.00
53.00	05300	ANESTHESIOLOGY	0	300	0	1,450	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,194	0	129,078	0 54.00
60.00	06000	LABORATORY	0	1,727	0	44,910	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	396	0	894	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	115	0	1,805	0 65.00
66.00	06600	PHYSICAL THERAPY	0	602	0	26,465	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	348	0	6,428	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	9	0	1,117	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	88	0	1,853	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	169	0	715	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	514	0	2,480	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,112	0	12,777	0 73.00
76.00	03950	NEUROLOGY	0	35	0	53	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,281	1,956	0	122,905	0 88.00
91.00	09100	EMERGENCY	233	1,126	0	30,969	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
93.00	04950	WOUND CARE	0	33	0	3,221	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	336	0	40,076	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,393	13,967	2,092	706,855	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0 194.00
194.01	07951	RENTAL SPACE	0	0	0	1,015	0 194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	159	0 194.02
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)	7,393	13,967	2,092	708,029	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 3:49 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
5.01	00560	PURCHASING RECEIVING AND STORES	5.01
5.02	00591	PERSONNEL	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	NEUROLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	WOUND CARE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	OPHTH CLINIC	194.00
194.01	07951	RENTAL SPACE	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,866					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		321,872				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,056,750			4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,692	0	57,996	2,039		5.01
5.02	00591	PERSONNEL	346	0	70,277	4	9,336,631	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,023	762	306,928	32	323,579	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	3,072	35,426	520,762	127	524,384	5.05
7.00	00700	OPERATION OF PLANT	10,460	1,680	189,303	16	189,303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	556	0	152,190	8	152,190	9.00
10.00	01000	DIETARY	1,540	0	217,111	11	217,111	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	156,516	14	156,516	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	18,697	454	18,697	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	184	258,528	0	258,528	16.00
17.00	01700	SOCIAL SERVICE	153	0	87,637	0	87,637	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,343	24,750	1,618,820	142	1,618,820	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,350	104,974	369,868	246	447,398	50.00
53.00	05300	ANESTHESIOLOGY	0	0	89,981	52	89,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609	103,634	332,817	81	332,817	54.00
60.00	06000	LABORATORY	1,523	22,869	467,765	51	467,765	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	10,502	0	10,502	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,068	56,013	0	56,013	65.00
66.00	06600	PHYSICAL THERAPY	2,610	0	277,934	35	277,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	209,251	0	209,251	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	4,129	0	4,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20	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	484	3,530	160,662	36	160,662	73.00
76.00	03950	NEUROLOGY	0	0	343	0	343	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,540	5,257	748,145	183	3,058,496	88.00
91.00	09100	EMERGENCY	1,320	2,954	458,290	411	458,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	59,262	2	59,262	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,820	13,184	157,023	114	157,023	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,749	321,872	7,056,750	2,039	9,336,631	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	376,935	331,094	1,994,186	72,315	100,721	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.628477	1.028651	0.282593	35.465915	0.010788	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	11,215	2,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	5.500245	0.000248	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:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.03	5A.05	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	25,054,648				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	-1,804,972	16,214,532		5.05
7.00	00700	OPERATION OF PLANT	0	0	673,755	40,273	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	37,162	1,332	9,348
9.00	00900	HOUSEKEEPING	0	0	226,275	556	0
10.00	01000	DIETARY	0	0	307,267	1,540	0
11.00	01100	CAFETERIA	0	0	3,931	593	0
13.00	01300	NURSING ADMINISTRATION	0	0	220,088	615	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	86,130	520	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	434,577	1,324	0
17.00	01700	SOCIAL SERVICE	0	0	115,134	153	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,673,116	0	2,348,868	9,343	4,602
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,264,752	0	813,445	2,350	939
53.00	05300	ANESTHESIOLOGY	305,121	0	197,941	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,142,127	0	853,059	1,609	616
60.00	06000	LABORATORY	3,265,072	0	1,151,957	1,523	0
64.00	06400	INTRAVENOUS THERAPY	748,661	0	68,164	0	0
65.00	06500	RESPIRATORY THERAPY	216,960	0	81,643	0	0
66.00	06600	PHYSICAL THERAPY	1,138,453	0	399,360	2,610	317
67.00	06700	OCCUPATIONAL THERAPY	657,228	0	288,362	495	0
68.00	06800	SPEECH PATHOLOGY	17,958	0	13,314	122	0
69.00	06900	ELECTROCARDIOLOGY	130,706	0	17,580	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	319,481	0	94,566	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	971,565	0	467,803	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,102,651	0	703,733	484	0
76.00	03950	NEUROLOGY	43,214	0	1,358	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,698,233	0	4,222,483	10,540	446
91.00	09100	EMERGENCY	1,661,039	0	2,005,087	1,320	2,395
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	WOUND CARE	62,447	0	83,006	307	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	635,864	0	292,931	2,820	33
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,054,648	-1,804,972	16,208,979	40,156	9,348
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
194.00	07950	OPHTH CLINIC	0	0	0	0	0
194.01	07951	RENTAL SPACE	0	0	776	117	0
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	4,777	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	530,175		1,804,972	748,756	66,064
203.00		Unit cost multiplier (Wkst. B, Part I)	0.021161		0.111318	18.592010	7.067180
204.00		Cost to be allocated (per Wkst. B, Part II)	7,821		57,633	73,592	11,395
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000312		0.003554	1.827328	1.218977
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
		9.00	10.00	11.00	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
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	29,361				9.00
10.00	01000	DIETARY	164	21,842			10.00
11.00	01100	CAFETERIA	0	12,856	10,645		11.00
13.00	01300	NURSING ADMINISTRATION	186	0	195	115,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	73	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	657	0	674	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	140	2,915	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,182	8,768	2,972	61,819	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,638	0	555	11,553	50.00
53.00	05300	ANESTHESIOLOGY	0	0	35	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,450	0	628	0	54.00
60.00	06000	LABORATORY	1,523	0	778	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	8	164	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	91	1,887	65.00
66.00	06600	PHYSICAL THERAPY	2,612	0	363	7,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	215	4,471	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	12	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406	0	195	4,064	73.00
76.00	03950	NEUROLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,650	0	2,390	0	88.00
91.00	09100	EMERGENCY	1,321	0	921	19,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	165	0	92	1,909	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	308	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,244	21,624	10,645	115,496	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	218	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	261,800	371,565	234,093	261,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.916590	17.011492	21.990888	2.268200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,587	14,260	13,423	6,380	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.190286	0.652871	1.260968	0.055240	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:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00560	PURCHASING RECEIVING AND STORES		5.01
5.02	00591	PERSONNEL		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.05	00590	ADMINISTRATIVE & GENERAL		5.05
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,413,850	16.00
17.00	01700	SOCIAL SERVICE	0 100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,673,116	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,822,204	50.00
53.00	05300	ANESTHESIOLOGY	567,969	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,156,691	54.00
60.00	06000	LABORATORY	3,265,072	60.00
64.00	06400	INTRAVENOUS THERAPY	748,661	64.00
65.00	06500	RESPIRATORY THERAPY	216,960	65.00
66.00	06600	PHYSICAL THERAPY	1,138,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	657,228	67.00
68.00	06800	SPEECH PATHOLOGY	17,958	68.00
69.00	06900	ELECTROCARDIOLOGY	165,412	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	319,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	971,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,102,651	73.00
76.00	03950	NEUROLOGY	66,097	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3,698,233	88.00
91.00	09100	EMERGENCY	2,127,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04950	WOUND CARE	62,447	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	635,864	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,413,850	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	OPHTH CLINIC	0	194.00
194.01	07951	RENTAL SPACE	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	528,249	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019999	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000529	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

		Description	Worksheet		Amount	
1.00			CODE	Line No.		
			2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00
7.00		IV THERAPY		1 30.00	-24,433	7.00
8.00		IV THERAPY		1 64.00	24,433	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,404,050		3,404,050	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,142,340		1,142,340	0	0	50.00
53.00	05300	ANESTHESIOLOGY	232,104		232,104	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,155		1,092,155	0	0	54.00
60.00	06000	LABORATORY	1,404,494		1,404,494	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	115,705		115,705	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	101,351	0	101,351	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,749	0	565,749	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,092	0	362,092	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,511	0	18,511	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,109		23,109	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,482		111,482	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	539,308		539,308	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	850,247		850,247	0	0	73.00
76.00	03950	NEUROLOGY	2,831		2,831	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,144,832		5,144,832	0	0	88.00
91.00	09100	EMERGENCY	2,391,328		2,391,328	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	140,435		140,435			92.00
93.00	04950	WOUND CARE	107,027		107,027	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	397,691		397,691	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,146,841	0	18,146,841	0	0	200.00
201.00		Less Observation Beds	140,435		140,435			201.00
202.00		Total (see instructions)	18,006,406	0	18,006,406	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,396,231		1,396,231		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	58,542	3,198,984	3,257,526	0.350677	0.000000
53.00	05300	ANESTHESIOLOGY	7,939	296,166	304,105	0.763236	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,328	3,989,461	4,090,789	0.266979	0.000000
60.00	06000	LABORATORY	181,543	3,036,033	3,217,576	0.436507	0.000000
64.00	06400	INTRAVENOUS THERAPY	301,955	444,500	746,455	0.155006	0.000000
65.00	06500	RESPIRATORY THERAPY	185,840	31,038	216,878	0.467318	0.000000
66.00	06600	PHYSICAL THERAPY	719,663	414,274	1,133,937	0.498925	0.000000
67.00	06700	OCCUPATIONAL THERAPY	496,418	146,648	643,066	0.563071	0.000000
68.00	06800	SPEECH PATHOLOGY	6,399	11,559	17,958	1.030794	0.000000
69.00	06900	ELECTROCARDIOLOGY	5,028	125,032	130,060	0.177680	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	210,435	108,295	318,730	0.349769	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,238	969,090	970,328	0.555800	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	953,050	1,145,527	2,098,577	0.405154	0.000000
76.00	03950	NEUROLOGY	0	42,790	42,790	0.066160	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	121,756	3,529,437	3,651,193		
91.00	09100	EMERGENCY	101	1,646,315	1,646,416	1.452445	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	276,885	276,885	0.507196	0.000000
93.00	04950	WOUND CARE	5,072	56,937	62,009	1.725991	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	635,864	635,864	0.625434	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	4,752,538	20,104,835	24,857,373		
201.00		Less Observation Beds					
202.00		Total (see instructions)	4,752,538	20,104,835	24,857,373		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 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
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 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	1,396,231		1,396,231		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	58,542	3,198,984	3,257,526	0.350677	0.000000
53.00	05300	ANESTHESIOLOGY	7,939	296,166	304,105	0.763236	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,328	3,989,461	4,090,789	0.266979	0.000000
60.00	06000	LABORATORY	181,543	3,036,033	3,217,576	0.436507	0.000000
64.00	06400	INTRAVENOUS THERAPY	301,955	444,500	746,455	0.155006	0.000000
65.00	06500	RESPIRATORY THERAPY	185,840	31,038	216,878	0.467318	0.000000
66.00	06600	PHYSICAL THERAPY	719,663	414,274	1,133,937	0.498925	0.000000
67.00	06700	OCCUPATIONAL THERAPY	496,418	146,648	643,066	0.563071	0.000000
68.00	06800	SPEECH PATHOLOGY	6,399	11,559	17,958	1.030794	0.000000
69.00	06900	ELECTROCARDIOLOGY	5,028	125,032	130,060	0.177680	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	210,435	108,295	318,730	0.349769	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,238	969,090	970,328	0.555800	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	953,050	1,145,527	2,098,577	0.405154	0.000000
76.00	03950	NEUROLOGY	0	42,790	42,790	0.066160	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	121,756	3,529,437	3,651,193	1.409082	0.000000
91.00	09100	EMERGENCY	101	1,646,315	1,646,416	1.452445	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	276,885	276,885	0.507196	0.000000
93.00	04950	WOUND CARE	5,072	56,937	62,009	1.725991	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	635,864	635,864	0.625434	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	4,752,538	20,104,835	24,857,373		
201.00		Less Observation Beds					
202.00		Total (see instructions)	4,752,538	20,104,835	24,857,373		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 3:49 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
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/24/2020 3:49 pm
Title XVIII				Hospital		Cost
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	141,922	3,257,526	0.043567	16,403	715	50.00
53.00 05300 ANESTHESIOLOGY	1,450	304,105	0.004768	1,276	6	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	129,078	4,090,789	0.031553	20,158	636	54.00
60.00 06000 LABORATORY	44,910	3,217,576	0.013958	21,647	302	60.00
64.00 06400 INTRAVENOUS THERAPY	894	746,455	0.001198	14,364	17	64.00
65.00 06500 RESPIRATORY THERAPY	1,805	216,878	0.008323	7,697	64	65.00
66.00 06600 PHYSICAL THERAPY	26,465	1,133,937	0.023339	2,723	64	66.00
67.00 06700 OCCUPATIONAL THERAPY	6,428	643,066	0.009996	1,470	15	67.00
68.00 06800 SPEECH PATHOLOGY	1,117	17,958	0.062201	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	1,853	130,060	0.014247	862	12	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	715	318,730	0.002243	6,321	14	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,480	970,328	0.002556	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12,777	2,098,577	0.006088	20,619	126	73.00
76.00 03950 NEUROLOGY	53	42,790	0.001239	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	122,905	3,651,193	0.033662	0	0	88.00
91.00 09100 EMERGENCY	30,969	1,646,416	0.018810	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5,682	276,885	0.020521	0	0	92.00
93.00 04950 WOUND CARE	3,221	62,009	0.051944	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	534,724	22,825,278		113,540	1,971	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950 WOUND CARE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 3:49 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	3,257,526	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	304,105	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	4,090,789	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	3,217,576	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	746,455	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	216,878	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,133,937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	643,066	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	17,958	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	130,060	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	318,730	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	970,328	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,098,577	0.000000	73.00
76.00	03950	NEUROLOGY	0	0	0	0	42,790	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,651,193	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	0	1,646,416	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	276,885	0.000000	92.00
93.00	04950	WOUND CARE	0	0	0	0	62,009	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0	0	0	22,825,278		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	16,403	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,276	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	20,158	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	21,647	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	14,364	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	7,697	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,723	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,470	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	862	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,321	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	20,619	0	0	0	73.00
76.00	03950 NEUROLOGY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950 WOUND CARE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		113,540	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/24/2020 3:49 pm		
					Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs		PPS 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	0.350677	0	777,346	0	0	0	50.00		
53.00	05300	ANESTHESIOLOGY	0.763236	0	81,545	0	0	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266979	0	1,169,056	0	0	0	54.00		
60.00	06000	LABORATORY	0.436507	0	712,548	0	0	0	60.00		
64.00	06400	INTRAVENOUS THERAPY	0.155006	0	136,197	0	0	0	64.00		
65.00	06500	RESPIRATORY THERAPY	0.467318	0	6,083	0	0	0	65.00		
66.00	06600	PHYSICAL THERAPY	0.498925	0	144,792	0	0	0	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.563071	0	43,474	0	0	0	67.00		
68.00	06800	SPEECH PATHOLOGY	1.030794	0	210	0	0	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	0.177680	0	36,851	0	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.349769	0	30,172	0	0	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555800	0	440,787	0	0	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405154	0	280,495	0	0	0	73.00		
76.00	03950	NEUROLOGY	0.066160	0	8,201	0	0	0	76.00		
	OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC							88.00		
91.00	09100	EMERGENCY	1.452445	0	374,851	0	0	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.507196	0	63,293	0	0	0	92.00		
93.00	04950	WOUND CARE	1.725991	0	26,185	0	0	0	93.00		
	OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	0.625434		0				95.00		
200.00		Subtotal (see instructions)		0	4,332,086	0	0	0	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		0		201.00		
202.00		Net Charges (line 200 - line 201)		0	4,332,086	0	0	0	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/24/2020 3:49 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	272,597	0					50.00
53.00	05300	ANESTHESIOLOGY	62,238	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,113	0					54.00
60.00	06000	LABORATORY	311,032	0					60.00
64.00	06400	INTRAVENOUS THERAPY	21,111	0					64.00
65.00	06500	RESPIRATORY THERAPY	2,843	0					65.00
66.00	06600	PHYSICAL THERAPY	72,240	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	24,479	0					67.00
68.00	06800	SPEECH PATHOLOGY	216	0					68.00
69.00	06900	ELECTROCARDIOLOGY	6,548	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,553	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	244,989	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,644	0					73.00
76.00	03950	NEUROLOGY	543	0					76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	544,450	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,102	0					92.00
93.00	04950	WOUND CARE	45,195	0					93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	2,076,893	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	2,076,893	0					202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN:14-1329 Component CCN:14-Z329	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/24/2020 3:49 pm
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Cost
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950 WOUND CARE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/24/2020 3:49 pm		
				Component CCN:14-Z329				
				Title XVIII	Swing Beds - SNF	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,257,526	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	304,105	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,090,789	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,217,576	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	746,455	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	216,878	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,133,937	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	643,066	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	17,958	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	130,060	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	318,730	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	970,328	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,098,577	0.000000	73.00
76.00	03950	NEUROLOGY	0	0	0	42,790	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,651,193	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	1,646,416	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	276,885	0.000000	92.00
93.00	04950	WOUND CARE	0	0	0	62,009	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	22,825,278		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN:14-1329 Period: From 07/01/2019 To 06/30/2020 Worksheet D Part IV Date/Time Prepared: 11/24/2020 3:49 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	995	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	36,950	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	79,037	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	286,480	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	110,686	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	446,399	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	314,130	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	4,644	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,940	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	118,044	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	367,352	0	0	0	73.00
76.00	03950 NEUROLOGY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950 WOUND CARE	0.000000	4,188	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,770,845	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:

Worksheet D

Component CCN:14-Z329

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:

11/24/2020 3:49 pm

		Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description		Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.350677	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.763236	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266979	0	0	0	54.00
60.00	06000	LABORATORY	0.436507	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.155006	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.467318	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.498925	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.563071	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.030794	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177680	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.349769	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555800	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.405154	0	0	0	73.00
76.00	03950	NEUROLOGY	0.066160	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	1.452445	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.507196	0	0	0	92.00
93.00	04950	WOUND CARE	1.725991	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.625434		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:

Worksheet D

Component CCN:14-Z329

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:

11/24/2020 3:49 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	NEUROLOGY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 3:49 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,017	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		205	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)		96	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,193	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)		1,192	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		214	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)		213	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		34	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)		819	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)		819	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		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,404,050	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)		33,639	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)		33,481	25.00
26.00	Total swing-bed cost (see instructions)		3,139,930	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		264,120	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)		264,120	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,288.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		43,805	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)		43,805	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 3:49 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)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					40,286
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					84,091
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,055,191
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,055,191
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH					2,110,382
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					109
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,288.39
89.00 Observation bed cost (line 87 x line 88) (see instructions)					140,435

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 3:49 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	137,737	3,404,050	0.040463	140,435	5,682	90.00
91.00 Nursing School cost	0	3,404,050	0.000000	140,435	0	91.00
92.00 Allied health cost	0	3,404,050	0.000000	140,435	0	92.00
93.00 All other Medical Education	0	3,404,050	0.000000	140,435	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1329

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

Worksheet D-3

Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		36,994		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.350677	16,403	5,752	50.00
53.00	05300 ANESTHESIOLOGY	0.763236	1,276	974	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.266979	20,158	5,382	54.00
60.00	06000 LABORATORY	0.436507	21,647	9,449	60.00
64.00	06400 INTRAVENOUS THERAPY	0.155006	14,364	2,227	64.00
65.00	06500 RESPIRATORY THERAPY	0.467318	7,697	3,597	65.00
66.00	06600 PHYSICAL THERAPY	0.498925	2,723	1,359	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.563071	1,470	828	67.00
68.00	06800 SPEECH PATHOLOGY	1.030794	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.177680	862	153	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.349769	6,321	2,211	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.555800	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.405154	20,619	8,354	73.00
76.00	03950 NEUROLOGY	0.066160	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.452445	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.507196	0	0	92.00
93.00	04950 WOUND CARE	1.725991	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		113,540	40,286	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		113,540		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1329

Period:

Worksheet D-3

Component CCN:14-Z329

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 3:49 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		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.350677	995	349	50.00
53.00	05300 ANESTHESIOLOGY	0.763236	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.266979	36,950	9,865	54.00
60.00	06000 LABORATORY	0.436507	79,037	34,500	60.00
64.00	06400 INTRAVENOUS THERAPY	0.155006	286,480	44,406	64.00
65.00	06500 RESPIRATORY THERAPY	0.467318	110,686	51,726	65.00
66.00	06600 PHYSICAL THERAPY	0.498925	446,399	222,720	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.563071	314,130	176,877	67.00
68.00	06800 SPEECH PATHOLOGY	1.030794	4,644	4,787	68.00
69.00	06900 ELECTROCARDIOLOGY	0.177680	1,940	345	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.349769	118,044	41,288	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.555800	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.405154	367,352	148,834	73.00
76.00	03950 NEUROLOGY	0.066160	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.452445	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.507196	0	0	92.00
93.00	04950 WOUND CARE	1.725991	4,188	7,228	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,770,845	742,925	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,770,845		202.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/24/2020 3:49 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			2,076,893	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)			2,076,893	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			2,097,662	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)			7,807	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			729,158	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)			1,360,697	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)			1,360,697	30.00
31.00	Primary payer payments			51	31.00
32.00	Subtotal (line 30 minus line 31)			1,360,646	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)			89,055	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			57,886	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			73,347	36.00
37.00	Subtotal (see instructions)			1,418,532	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)			1,418,532	40.00
40.01	Sequestration adjustment (see instructions)			23,689	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			1,167,793	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)			227,050	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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN:14-1329		Period: From 07/01/2019 To 06/30/2020	
		Title XVIII		Hospital	
		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		48,130		1,126,164
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/17/2020	20,081	06/17/2020	98,895
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	01/15/2020	57,266
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		20,081		41,629
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)		68,211		1,167,793
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		9,729		227,050
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		77,940		1,394,843
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1329

Period:

Worksheet E-1

Component CCN:14-Z329

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/24/2020 3:49 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		2,450,477		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	01/15/2020	6,650		0	3.01
3.02		06/17/2020	46,456		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)		53,106		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)		2,503,583		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		285,883		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,789,466		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:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/24/2020 3:49 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:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2
		Component CCN:14-Z329		Date/Time Prepared: 11/24/2020 3:49 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)	2,131,486	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 V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	Part 750,354	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,638	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)	2,881,840	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,881,840	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)	2,881,840	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	45,045	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,836,795	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)	71	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	46	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,836,841	0	19.00
19.01	Sequestration adjustment (see instructions)	47,375	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	2,503,583	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)	285,883	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)	1		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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/24/2020 3:49 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			84,091	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)			84,091	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			84,091	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)			84,091	19.00
20.00	Deductibles (exclude professional component)			8,228	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			75,863	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			75,863	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,233	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			3,401	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,092	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			79,264	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			79,264	30.00
30.01	Sequestration adjustment (see instructions)			1,324	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			68,211	31.00
31.01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)				32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			9,729	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)				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:14-1329		Period: From 07/01/2019 To 06/30/2020		Worksheet G Date/Time Prepared: 11/24/2020 3:49 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	7,941,217	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	3,291,728	0	0	0	4.00	
5.00	Other receivable	970,669	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	366,753	0	0	0	7.00	
8.00	Prepaid expenses	74,499	0	0	0	8.00	
9.00	Other current assets	0	0	0	0	9.00	
10.00	Due from other funds	108,553	0	0	0	10.00	
11.00	Total current assets (sum of lines 1-10)	12,753,419	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	214,162	0	0	0	12.00	
13.00	Land improvements	429,924	0	0	0	13.00	
14.00	Accumulated depreciation	-332,336	0	0	0	14.00	
15.00	Buildings	19,468,805	0	0	0	15.00	
16.00	Accumulated depreciation	-6,527,113	0	0	0	16.00	
17.00	Leasehold improvements	0	0	0	0	17.00	
18.00	Accumulated depreciation	0	0	0	0	18.00	
19.00	Fixed equipment	1,225,959	0	0	0	19.00	
20.00	Accumulated depreciation	-801,207	0	0	0	20.00	
21.00	Automobiles and trucks	0	0	0	0	21.00	
22.00	Accumulated depreciation	0	0	0	0	22.00	
23.00	Major movable equipment	5,423,503	0	0	0	23.00	
24.00	Accumulated depreciation	-4,790,173	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)	14,311,524	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	0	0	0	0	31.00	
32.00	Deposits on leases	0	0	0	0	32.00	
33.00	Due from owners/officers	0	0	0	0	33.00	
34.00	Other assets	548	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	548	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	27,065,491	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	1,390,473	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	698,298	0	0	0	38.00	
39.00	Payroll taxes payable	303,479	0	0	0	39.00	
40.00	Notes and loans payable (short term)	677,653	0	0	0	40.00	
41.00	Deferred income	526,050	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	4,909,842	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	8,505,795	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	0	0	0	0	46.00	
47.00	Notes payable	10,277,482	0	0	0	47.00	
48.00	Unsecured loans	0	0	0	0	48.00	
49.00	Other long term liabilities	0	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,277,482	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	18,783,277	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	8,282,214				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						58.00
59.00	Total fund balances (sum of lines 52 thru 58)	8,282,214	0		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,065,491	0		0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-1329

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

Worksheet G-1

Date/Time Prepared:
11/24/2020 3:49 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		7,204,120		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,078,094				2.00
3.00	Total (sum of line 1 and line 2)		8,282,214		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)		8,282,214		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)		8,282,214		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:14-1329

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2020 3:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	386,815		386,815	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,270,301		1,270,301	5.00
6.00	Swing bed - NF	28,002		28,002	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)	1,685,118		1,685,118	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)	1,685,118		1,685,118	17.00
18.00	Ancillary services	3,119,792	15,084,607	18,204,399	18.00
19.00	Outpatient services	5,173	2,185,062	2,190,235	19.00
20.00	RURAL HEALTH CLINIC	121,756	3,576,477	3,698,233	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	635,864	635,864	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	G-3, 4,931,839	21,482,010	26,413,849	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,941,080		29.00
30.00	CHARITY CARE RHC SLIDING FEE	8,018			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		8,018		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)		18,949,098		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-1329

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

Worksheet G-3

Date/Time Prepared:
11/24/2020 3:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,413,849	1.00
2.00	Less contractual allowances and discounts on patients' accounts	10,335,120	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,078,729	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,949,098	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,870,369	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,817	6.00
7.00	Income from investments	13,733	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	OTHER OPERATING REVENUE	247,368	24.00
24.01	COUNTY TAX REVENUE	1,002,908	24.01
24.02	STATE TAX REVENUE	94,476	24.02
24.03	PROVIDER RELIEF FUND GRANT REVENUE	2,600,587	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,963,889	25.00
26.00	Total (line 5 plus line 25)	1,093,520	26.00
27.00	GAIN ON DISPOSAL OF CAPITAL ASSETS	-6,647	27.00
27.01	CHARITY CARE	22,073	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	15,426	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,078,094	29.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN:14-1329 Component CCN:14-3981		Period: From 07/01/2019 To 06/30/2020		Worksheet M-1 Date/Time Prepared: 11/24/2020 3:49 pm	
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,825,096	0	1,825,096	0	1,825,096	1.00
2.00	Physician Assistant	130,002	0	130,002	0	130,002	2.00
3.00	Nurse Practitioner	239,525	0	239,525	0	239,525	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	152,116	0	152,116	0	152,116	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	670,614	0	670,614	0	670,614	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,017,353	0	3,017,353	0	3,017,353	10.00
11.00	Physician Services Under Agreement	0	468,742	468,742	0	468,742	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	468,742	468,742	0	468,742	14.00
15.00	Medical Supplies	0	24,540	24,540	0	24,540	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	33,756	33,756	-33,756	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	58,296	58,296	-33,756	24,540	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,017,353	527,038	3,544,391	-33,756	3,510,635	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	41,143	0	41,143	0	41,143	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)	41,143	0	41,143	0	41,143	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	33,403	33,403	0	33,403	29.00
30.00	Administrative Costs	0	79,304	79,304	270,542	349,846	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	112,707	112,707	270,542	383,249	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,058,496	639,745	3,698,241	236,786	3,935,027	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1329

Period:

Worksheet M-1

Component CCN:14-3981

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 3:49 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,825,096		1.00
2.00	Physician Assistant	0	130,002		2.00
3.00	Nurse Practitioner	-116,979	122,546		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	152,116		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	670,614		9.00
10.00	Subtotal (sum of lines 1 through 9)	-116,979	2,900,374		10.00
11.00	Physician Services Under Agreement	0	468,742		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	468,742		14.00
15.00	Medical Supplies	0	24,540		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	24,540		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-116,979	3,393,656		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	41,143		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	41,143		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	33,403		29.00
30.00	Administrative Costs	0	349,846		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	383,249		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-116,979	3,818,048		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN:14-1329 Component CCN:14-3981	Period: From 07/01/2019 To 06/30/2020	Worksheet M-2 Date/Time Prepared: 11/24/2020 3:49 pm
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		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	4.59	12,102	3,616	16,597	1.00
2.00	Physician Assistant	0.77	2,487	2,100	1,617	2.00
3.00	Nurse Practitioner	0.66	3,390	2,100	1,386	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.02	17,979		19,600	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	1.90	2,006		2,006	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)	7.92	19,985		21,606	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)				3,393,656	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				41,143	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,434,799	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.988022	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				383,249	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,326,784	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,710,033	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,710,033	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,689,550	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,083,206	20.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3		
		Component CCN:14-3981		Date/Time Prepared: 11/24/2020 3:49 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)			5,083,206	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			16,680	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,066,526	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,606	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)			21,606	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			234.50	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			234.50	234.50	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	3,629	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	851,001	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	287	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	67,302	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	67,302	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	918,303	16.00
16.01	Total program charges (see instructions)(from contractor's records)				798,413	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				917	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				1,055	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.)				706,160	16.04
16.05	Total program cost (see instructions)			0	707,215	16.05
17.00	Primary payer amounts				928	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				34,548	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				152,401	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				706,287	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				2,937	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				709,224	22.00
23.00	Allowable bad debts (see instructions)				71,713	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				46,613	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				66,055	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.01	TELEHEALTH				0	25.01
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)				755,837	26.00
26.01	Sequestration adjustment (see instructions)				12,622	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				647,495	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)				95,720	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:14-1329 Component CCN:14-3981	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/24/2020 3:49 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)		2,900,374	2,900,374	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000164	0.000178	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		476	516	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,336	1,807	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,812	2,323	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,393,656	3,393,656	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,689,550	1,689,550	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002597	0.000685	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,388	1,157	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		13,200	3,480	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		49	53	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		269.39	65.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		7	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,886	1,051	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)			16,680	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)			2,937	16.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1329	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5	
		Component CCN:14-3981		Date/Time Prepared: 11/24/2020 3:49 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			507,662	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			06/17/2020	139,833	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)			139,833	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			647,495	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			95,720	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			743,215	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00