

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 9:16 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/2/2021	Time: 9:16 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION COUNTY HOSPITAL DISTRICT (14-1342) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MIKE HARBOR

Officer or Administrator of Provider(s)

CFO

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	488,372	886,002	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	178,013	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		37,124		0	10.00
200.00	Total	0	666,385	923,126	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1342		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:16 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 517 NORTH MAIN STREET			PO Box:				1.00	
2.00	City: ANNA			State: IL		Zip Code: 62906		County: UNION	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1342

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:16 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:16 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	51,110	32,563	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:16 am
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	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: QUORUM HEALTH CORPORATION	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE	PO Box: SUITE 100		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y
			1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N
			1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N
		Part A	Part B	Title V
		1.00	2.00	3.00
				Title XIX
				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	Y	Y	N
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N
				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
	Name	County	State	Zip Code
	0	1.00	2.00	3.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			0.00
				1.00
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y
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)			1.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 9:16 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/13/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 9:16 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINTON	BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3869	CBALLEW@QHCUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/2/2021 9:16 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER	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: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	34,536.00	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	34,536.00	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	34,536.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	22	8,052			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)		47				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	870	14	1,439			1.00
2.00	HMO and other (see instructions)	151	169				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	346	0	500			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,216	14	1,939			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)	1,216	14	1,939	0.00	104.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			4,994	0.00	14.83	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	537	0	4,964	0.00	6.68	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	125.87	27.00
28.00	Observation Bed Days		0	197			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	218	5	393	1.00
2.00 HMO and other (see instructions)			42	61		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	218	5	393	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 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		UNION COUNTY HOSPITAL DISTRICT		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1342 Component CCN: 14-3975		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 8/2/2021 9:16 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	517 NORTH MAIN STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL 62906	2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				
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.)	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		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	UNION			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342

Period:

Worksheet S-8

Component CCN: 14-3975

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

Date/Time Prepared:

8/2/2021 9:16 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	17:00	09:00	16:50		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 9:16 am	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.298894	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,029,980	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,532,837	5.00	
6.00	Medicaid charges		20,354,650	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,083,883	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,521,066	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,521,066	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,004,631	0	1,004,631	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	300,278	0	300,278	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	300,278	0	300,278	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)		1,376,195	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		682,580	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,050,124	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		326,071	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		465,005	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		765,283	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,286,349	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		156,740	156,740	99,948	256,688	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,093,917	1,093,917	2,598	1,096,515	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	107,252	18,861	126,113	1,242,502	1,368,615	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	275	1,242,917	1,243,192	36,249	1,279,441	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,474,128	5,558,709	7,032,837	-1,498,112	5,534,725	5.02
7.00	00700	OPERATION OF PLANT	276,998	793,608	1,070,606	9,142	1,079,748	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,406	4,012	37,418	0	37,418	8.00
9.00	00900	HOUSEKEEPING	226,283	82,344	308,627	28,396	337,023	9.00
10.00	01000	DIETARY	0	579,637	579,637	0	579,637	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	848,367	86,225	934,592	-382,609	551,983	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,745	122,294	210,039	-113,675	96,364	14.00
15.00	01500	PHARMACY	286,233	501,127	787,360	-388,471	398,889	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,067	19,067	0	19,067	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	744,648	979,594	1,724,242	440,918	2,165,160	30.00
46.00	04600	OTHER LONG TERM CARE	702,052	114,449	816,501	-37,538	778,963	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	240,196	124,574	364,770	63,922	428,692	50.00
51.00	05100	RECOVERY ROOM	60,322	7,348	67,670	-67,670	0	51.00
53.00	05300	ANESTHESIOLOGY	0	275,589	275,589	0	275,589	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,155	129,824	490,979	382,974	873,953	54.00
54.01	05401	ULTRASOUND	89,218	16,956	106,174	-106,174	0	54.01
56.00	05600	RADIOISOTOPE	0	74,266	74,266	-74,266	0	56.00
57.00	05700	CT SCAN	33,856	13,616	47,472	-47,472	0	57.00
58.00	05800	MRI	47,326	107,736	155,062	-155,062	0	58.00
60.00	06000	LABORATORY	386,259	585,067	971,326	0	971,326	60.00
65.00	06500	RESPIRATORY THERAPY	109,677	39,814	149,491	-29,902	119,589	65.00
66.00	06600	PHYSICAL THERAPY	303,595	36,913	340,508	0	340,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,676	12,816	173,492	0	173,492	67.00
68.00	06800	SPEECH PATHOLOGY	73,570	6,331	79,901	0	79,901	68.00
69.00	06900	ELECTROCARDIOLOGY	72,897	43,003	115,900	0	115,900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,928	105,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,055	42,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	387,813	387,813	73.00
76.00	03610	SLEEP LAB	0	84,957	84,957	0	84,957	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	437,594	437,594	0	437,594	76.01
76.03	03950	WOUND CARE	24,240	37,474	61,714	0	61,714	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	576,009	413,484	989,493	-36,249	953,244	88.00
91.00	09100	EMERGENCY	931,810	1,304,157	2,235,967	0	2,235,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,258,193	15,105,020	23,363,213	-94,755	23,268,458	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,464	30,464	117	30,581	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	94,638	94,638	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	513	513	0	513	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,258,193	15,135,997	23,394,190	0	23,394,190	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	710,134	966,822	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-610,939	485,576	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,368,615	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,279,441	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,226,627	4,308,098	5.02
7.00	00700	OPERATION OF PLANT	-1,204	1,078,544	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,418	8.00
9.00	00900	HOUSEKEEPING	0	337,023	9.00
10.00	01000	DIETARY	0	579,637	10.00
11.00	01100	CAFETERIA	-30,011	-30,011	11.00
13.00	01300	NURSING ADMINISTRATION	0	551,983	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,364	14.00
15.00	01500	PHARMACY	0	398,889	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-200	18,867	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-834,357	1,330,803	30.00
46.00	04600	OTHER LONG TERM CARE	-54,147	724,816	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	428,692	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	275,589	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-518	873,435	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	971,326	60.00
65.00	06500	RESPIRATORY THERAPY	0	119,589	65.00
66.00	06600	PHYSICAL THERAPY	0	340,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,492	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0	115,900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	105,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	387,813	73.00
76.00	03610	SLEEP LAB	0	84,957	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	437,594	76.01
76.03	03950	WOUND CARE	0	61,714	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-270,947	682,297	88.00
91.00	09100	EMERGENCY	-502,669	1,733,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,821,485	20,446,973	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,581	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	94,638	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	513	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,821,485	20,572,705	200.00

RECLASSIFICATIONS

Provider CCN: 14-1342

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 9:16 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - EMPLOYEE BENEFITS					
1.00 EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,242,502		1.00
2.00 PHYSICIANS' PRIVATE OFFICES	192.00	0	117		2.00
0		0	1,242,619		
B - OXYGEN					
1.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,902		1.00
0		0	29,902		
D - OTHER CAPITAL COSTS					
1.00 CAP REL COSTS-BLDG & FIXT	1.00	0	35,765		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	2,598		2.00
3.00 CAP REL COSTS-BLDG & FIXT	1.00	0	64,183		3.00
0		0	102,546		
E - MARKETING DEPT					
1.00 OTHER NONREIMBURSABLE - MARKETING	194.01	62,321	32,317		1.00
0		62,321	32,317		
F - MED SUPPLIES					
1.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	76,026		1.00
2.00 IMPL. DEV. CHARGED TO PATIENTS	72.00	0	42,055		2.00
3.00	0.00	0	0		3.00
0		0	118,081		
G - COST OF DRUGS					
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	387,813		1.00
0		0	387,813		
J - OTHER RADIOLOGY COSTS					
1.00 RADIOLOGY-DIAGNOSTIC	54.00	170,400	212,574		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
0		170,400	212,574		
K - RECOVERY ROOM					
1.00 OPERATING ROOM	50.00	60,322	7,348		1.00
0		60,322	7,348		
M - RHC SALARY TO ADMIN					
1.00 CASHIERING/ACCOUNTS RECEIVABLE	5.01	36,249	0		1.00
0		36,249	0		
N - INFECTION CONTROL					
1.00 NURSING ADMINISTRATION	13.00	50,522	7,787		1.00
0		50,522	7,787		
O - RECLASS COSTS TO HSKP AND MAINT					
1.00 OPERATION OF PLANT	7.00	9,142	0		1.00
2.00 HOUSEKEEPING	9.00	28,396	0		2.00
0		37,538	0		
P - HOUSE SUPVR TO ADULT AND PED					
1.00 ADULTS & PEDIATRICS	30.00	440,918	0		1.00
0		440,918	0		
500.00 Grand Total: Increases		858,270	2,140,987		500.00

RECLASSIFICATIONS

Provider CCN: 14-1342

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 9:16 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,242,619	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	1,242,619		
B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	29,902	0	1.00
	0		0	29,902		
D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	102,546	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	13	3.00
	0		0	102,546		
E - MARKETING DEPT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	62,321	32,317	0	1.00
	0		62,321	32,317		
F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	113,675	0	1.00
2.00	OPERATING ROOM	50.00	0	3,748	0	2.00
3.00	PHARMACY	15.00	0	658	0	3.00
	0		0	118,081		
G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	387,813	0	1.00
	0		0	387,813		
J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	89,218	16,956	0	1.00
2.00	RADIOISOTOPE	56.00	0	74,266	0	2.00
3.00	CT SCAN	57.00	33,856	13,616	0	3.00
4.00	MRI	58.00	47,326	107,736	0	4.00
	0		170,400	212,574		
K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	60,322	7,348	0	1.00
	0		60,322	7,348		
M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	36,249	0	0	1.00
	0		36,249	0		
N - INFECTION CONTROL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	50,522	7,787	0	1.00
	0		50,522	7,787		
O - RECLASS COSTS TO HSKP AND MAINT						
1.00	OTHER LONG TERM CARE	46.00	37,538	0	0	1.00
2.00		0.00	0	0	0	2.00
	0		37,538	0		
P - HOUSE SUPVR TO ADULT AND PED						
1.00	NURSING ADMINISTRATION	13.00	440,918	0	0	1.00
	0		440,918	0		
500.00	Grand Total: Decreases		858,270	2,140,987		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/2/2021 9:16 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	183,326	16,952	0	16,952	0	2.00	
3.00	Buildings and Fixtures	6,846,397	0	0	0	0	3.00	
4.00	Building Improvements	12,560,152	918,238	0	918,238	16,122	4.00	
5.00	Fixed Equipment	2,374,917	166,370	0	166,370	3,409	5.00	
6.00	Movable Equipment	8,383,427	616,472	0	616,472	273,143	6.00	
7.00	HIT designated Assets	3,248,805	5,322	0	5,322	0	7.00	
8.00	Subtotal (sum of lines 1-7)	33,597,024	1,723,354	0	1,723,354	292,674	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	33,597,024	1,723,354	0	1,723,354	292,674	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	200,278	0				2.00	
3.00	Buildings and Fixtures	6,846,397	0				3.00	
4.00	Building Improvements	13,462,268	0				4.00	
5.00	Fixed Equipment	2,537,878	0				5.00	
6.00	Movable Equipment	8,726,756	0				6.00	
7.00	HIT designated Assets	3,254,127	0				7.00	
8.00	Subtotal (sum of lines 1-7)	35,027,704	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	35,027,704	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	156,740	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,093,917	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,250,657	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	156,740				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,093,917				2.00
3.00	Total (sum of lines 1-2)	0	1,250,657				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,046,821	0	23,046,821	0.657960	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,980,883	0	11,980,883	0.342040	0	2.00
3.00	Total (sum of lines 1-2)	35,027,704	0	35,027,704	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	866,874	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	482,978	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,349,852	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	0	35,765	64,183	0	966,822	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,598	0	0	485,576	2.00
3.00	Total (sum of lines 1-2)	0	38,363	64,183	0	1,452,398	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,833	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-530	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,337,026			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	174,133			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-30,011	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-200	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	A	631,893	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-636,254	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	FITNESS REVENUE	B	-4,325	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.02	IL PROVIDER TAX	B	-1,131,014	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
34.00	LOBBY EXPENSE	A	-14,250	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.00
34.01	CHARITABLE CONTRIBUTIONS	A	-22,296	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.01
35.00	RADIOLOGY OTHER REVENUE	B	-518	RADIOLOGY-DIAGNOSTIC	54.00	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-316	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-1,204	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-83,868	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	IL PROVIDER TAX FOR NH	A	-54,147	OTHER LONG TERM CARE	46.00	0	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-8,903	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	40.00
41.00	MISCELLANEOUS INCOME	B	-24,869	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
41.01	PATIENT PHONE WAGES	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.01
41.02	MIS AMORTIZATION ADJUSTMENT	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.02
42.00	ADMIN SERVICES ALLOCATED TO RHC	A	-270,947	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	FLOWERS SENT FOR DECEASED NH RESIDEN	A	0	OTHER LONG TERM CARE	46.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,821,485				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
8/2/2021 9:16 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	78,241	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	26,161	0
3.00		5.02	OTHER ADMINISTRATIVE AND GEN	ALLOCATED COSTS	1,009,453	775,524
3.01		5.02	OTHER ADMINISTRATIVE AND GEN	DIRECT COSTS	16,813	0
4.00		5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	83,673	264,684
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,214,341	1,040,208	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

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

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

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

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

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
8/2/2021 9:16 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	78,241	9		1.00
2.00	26,161	9		2.00
3.00	233,929	0		3.00
3.01	16,813	0		3.01
4.00	-181,011	0		4.00
5.00	174,133			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1342

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

Worksheet A-8-2

Date/Time Prepared:
8/2/2021 9:16 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	834,357	834,357	0	0	0	1.00
2.00	91.00	EMERGENCY	1,117,042	502,669	614,373	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,951,399	1,337,026	614,373		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	834,357		1.00
2.00	91.00	EMERGENCY	0	0	0	502,669		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,337,026		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	966,822	966,822			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	485,576		485,576		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,368,615	7,553	3,828	1,379,996	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,279,441	18,407	9,330	6,184	1,313,362
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	4,308,098	183,747	93,132	230,472	0
7.00	00700	OPERATION OF PLANT	1,078,544	138,826	70,364	48,445	0
8.00	00800	LAUNDRY & LINEN SERVICE	37,418	16,306	8,265	5,656	0
9.00	00900	HOUSEKEEPING	337,023	12,462	6,316	43,118	0
10.00	01000	DIETARY	579,637	30,792	15,607	0	0
11.00	01100	CAFETERIA	-30,011	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	551,983	26,803	13,585	77,537	0
14.00	01400	CENTRAL SERVICES & SUPPLY	96,364	19,017	9,639	14,856	0
15.00	01500	PHARMACY	398,889	11,920	6,042	48,461	0
16.00	01600	MEDICAL RECORDS & LIBRARY	18,867	11,077	5,615	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,330,803	69,040	34,993	200,722	66,150
46.00	04600	OTHER LONG TERM CARE	724,816	57,527	29,158	112,506	13,466
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	428,692	37,967	19,244	50,879	66,905
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	275,589	0	0	0	13,369
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,435	61,129	30,983	89,995	472,999
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	971,326	16,916	8,574	65,396	230,155
65.00	06500	RESPIRATORY THERAPY	119,589	2,547	1,291	18,569	5,555
66.00	06600	PHYSICAL THERAPY	340,508	42,886	21,737	51,400	44,300
67.00	06700	OCCUPATIONAL THERAPY	173,492	9,683	4,908	27,203	11,333
68.00	06800	SPEECH PATHOLOGY	79,901	1,346	682	12,456	4,064
69.00	06900	ELECTROCARDIOLOGY	115,900	7,349	3,725	12,342	26,677
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,928	0	0	0	15,109
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,055	0	0	0	2,850
73.00	07300	DRUGS CHARGED TO PATIENTS	387,813	0	0	0	102,201
76.00	03610	SLEEP LAB	84,957	3,447	1,747	0	3,857
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	437,594	7,466	3,784	0	10,440
76.03	03950	WOUND CARE	61,714	5,945	3,013	4,104	2,326
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	682,297	32,206	16,324	91,384	13,825
91.00	09100	EMERGENCY	1,733,298	43,990	22,297	157,760	207,781
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,446,973	876,354	444,183	1,369,445	1,313,362
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,551	2,307	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,581	55,677	28,220	0	0
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	94,638	3,786	1,919	10,551	0
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	513	4,406	2,233	0	0
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0
194.04	07954	LEASED TO SPECIALTY CLINICS	0	13,246	6,714	0	0
194.05	07955	VACANT SPACE	0	8,802	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	20,572,705	966,822	485,576	1,379,996	1,313,362

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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	Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	4,815,449	4,815,449				5.02
7.00	00700	OPERATION OF PLANT	1,336,179	407,563	1,743,742			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,645	20,633	46,653	134,931		8.00
9.00	00900	HOUSEKEEPING	398,919	121,679	35,655	4,223	560,476	9.00
10.00	01000	DIETARY	626,036	190,954	88,099	801	29,719	10.00
11.00	01100	CAFETERIA	-30,011	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	669,908	204,336	76,657	0	25,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,876	42,665	54,411	0	18,355	14.00
15.00	01500	PHARMACY	465,312	141,930	34,104	0	11,504	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,559	10,846	31,693	0	10,691	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,701,708	519,057	197,528	29,886	66,635	30.00
46.00	04600	OTHER LONG TERM CARE	937,473	285,949	164,589	59,650	55,521	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	603,687	184,137	108,627	5,118	36,644	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	288,958	88,138	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,528,541	466,237	174,895	4,703	58,998	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,292,367	394,199	48,399	0	16,327	60.00
65.00	06500	RESPIRATORY THERAPY	147,551	45,006	7,286	0	2,458	65.00
66.00	06600	PHYSICAL THERAPY	500,831	152,764	122,701	6,979	41,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	226,619	69,124	27,704	0	9,345	67.00
68.00	06800	SPEECH PATHOLOGY	98,449	30,029	3,851	0	1,299	68.00
69.00	06900	ELECTROCARDIOLOGY	165,993	50,631	21,027	0	7,093	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,037	36,919	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,905	13,697	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	490,014	149,465	0	0	0	73.00
76.00	03610	SLEEP LAB	94,008	28,674	9,863	0	3,327	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	459,284	140,091	21,360	0	7,205	76.01
76.03	03950	WOUND CARE	77,102	23,518	17,010	0	5,738	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	836,036	255,009	92,116	994	31,083	88.00
91.00	09100	EMERGENCY	2,165,126	660,409	125,859	22,577	42,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		20,304,561	4,733,659	1,510,087	134,931	481,657	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,858	2,092	13,021	0	4,392	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,478	34,918	159,298	0	53,736	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	110,894	33,825	10,832	0	3,654	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	7,152	2,182	12,605	0	4,252	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	19,960	6,088	37,899	0	12,785	194.04
194.05	07955	VACANT SPACE	8,802	2,685	0	0	0	194.05
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)	20,572,705	4,815,449	1,743,742	134,931	560,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	935,609					10.00
11.00	01100	CAFETERIA	230,690	200,679				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,789	989,558			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,212	0	259,519		14.00
15.00	01500	PHARMACY	0	5,221	0	5,122	663,193	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	960	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	208,638	35,408	451,144	17,621	0	30.00
46.00	04600	OTHER LONG TERM CARE	496,281	32,532	0	4,477	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,990	114,356	25,455	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,289	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,756	0	3,780	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	14,171	0	96,078	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,168	41,735	840	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,499	0	1,740	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,168	0	271	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,645	0	407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,172	27,740	284	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,201	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,782	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	663,193	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	703	0	76.01
76.03	03950	WOUND CARE	0	1,382	0	1,321	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	14,654	0	5,090	0	88.00
91.00	09100	EMERGENCY	0	26,960	354,583	27,946	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	935,609	198,727	989,558	259,367	663,193	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	1,952	0	117	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	35	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	935,609	200,679	989,558	259,519	663,193	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,749				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,519	3,232,144	0	3,232,144	30.00
46.00	04600	OTHER LONG TERM CARE	920	2,037,392	0	2,037,392	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,571	1,093,585	0	1,093,585	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	913	380,298	0	380,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,341	2,288,251	0	2,288,251	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	15,723	1,877,264	0	1,877,264	60.00
65.00	06500	RESPIRATORY THERAPY	379	249,423	0	249,423	65.00
66.00	06600	PHYSICAL THERAPY	3,026	838,931	0	838,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	774	338,005	0	338,005	67.00
68.00	06800	SPEECH PATHOLOGY	278	135,958	0	135,958	68.00
69.00	06900	ELECTROCARDIOLOGY	1,822	276,762	0	276,762	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,032	205,189	0	205,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195	77,579	0	77,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,982	1,309,654	0	1,309,654	73.00
76.00	03610	SLEEP LAB	264	136,136	0	136,136	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	713	629,356	0	629,356	76.01
76.03	03950	WOUND CARE	159	126,230	0	126,230	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	944	1,235,926	0	1,235,926	88.00
91.00	09100	EMERGENCY	14,194	3,440,110	0	3,440,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,749	19,908,193	0	19,908,193	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,363	0	26,363	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	362,430	0	362,430	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	161,274	0	161,274	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	26,226	0	26,226	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	76,732	0	76,732	194.04
194.05	07955	VACANT SPACE	0	11,487	0	11,487	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,749	20,572,705	0	20,572,705	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,553	3,828	11,381	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	18,407	9,330	27,737	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	183,747	93,132	276,879	5.02
7.00	00700	OPERATION OF PLANT	0	138,826	70,364	209,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,306	8,265	24,571	8.00
9.00	00900	HOUSEKEEPING	0	12,462	6,316	18,778	9.00
10.00	01000	DIETARY	0	30,792	15,607	46,399	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,803	13,585	40,388	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,017	9,639	28,656	14.00
15.00	01500	PHARMACY	0	11,920	6,042	17,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,077	5,615	16,692	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	69,040	34,993	104,033	30.00
46.00	04600	OTHER LONG TERM CARE	0	57,527	29,158	86,685	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	37,967	19,244	57,211	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,129	30,983	92,112	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	16,916	8,574	25,490	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,547	1,291	3,838	65.00
66.00	06600	PHYSICAL THERAPY	0	42,886	21,737	64,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,683	4,908	14,591	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,346	682	2,028	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,349	3,725	11,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	3,447	1,747	5,194	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	7,466	3,784	11,250	76.01
76.03	03950	WOUND CARE	0	5,945	3,013	8,958	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	32,206	16,324	48,530	88.00
91.00	09100	EMERGENCY	0	43,990	22,297	66,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	876,354	444,183	1,320,537	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,551	2,307	6,858	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,677	28,220	83,897	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	3,786	1,919	5,705	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	4,406	2,233	6,639	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	13,246	6,714	19,960	194.04
194.05	07955	VACANT SPACE	0	8,802	0	8,802	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	966,822	485,576	1,452,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	27,788					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	278,780				5.02
7.00	00700	OPERATION OF PLANT	0	23,596	233,185			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,195	6,239	32,052		8.00
9.00	00900	HOUSEKEEPING	0	7,045	4,768	1,003	31,950	9.00
10.00	01000	DIETARY	0	11,055	11,781	190	1,694	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,830	10,251	0	1,475	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,470	7,276	0	1,046	14.00
15.00	01500	PHARMACY	0	8,217	4,561	0	656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	628	4,238	0	609	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,399	30,050	26,416	7,099	3,799	30.00
46.00	04600	OTHER LONG TERM CARE	285	16,555	22,010	14,170	3,165	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,415	10,661	14,526	1,216	2,089	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	283	5,103	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,016	26,993	23,388	1,117	3,363	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,867	22,822	6,472	0	931	60.00
65.00	06500	RESPIRATORY THERAPY	117	2,606	974	0	140	65.00
66.00	06600	PHYSICAL THERAPY	937	8,844	16,408	1,658	2,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	240	4,002	3,705	0	533	67.00
68.00	06800	SPEECH PATHOLOGY	86	1,739	515	0	74	68.00
69.00	06900	ELECTROCARDIOLOGY	564	2,931	2,812	0	404	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	320	2,137	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60	793	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,161	8,653	0	0	0	73.00
76.00	03610	SLEEP LAB	82	1,660	1,319	0	190	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	221	8,110	2,856	0	411	76.01
76.03	03950	WOUND CARE	49	1,362	2,275	0	327	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	292	14,764	12,318	236	1,772	88.00
91.00	09100	EMERGENCY	4,394	38,225	16,831	5,363	2,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,788	274,046	201,939	32,052	27,458	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	121	1,741	0	250	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,022	21,302	0	3,063	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	1,958	1,449	0	208	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	126	1,686	0	242	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	352	5,068	0	729	194.04
194.05	07955	VACANT SPACE	0	155	0	0	0	194.05
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)	27,788	278,780	233,185	32,052	31,950	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	71,119					10.00
11.00	01100	CAFETERIA	17,536	15,255				11.00
13.00	01300	NURSING ADMINISTRATION	0	972	65,555			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	320	0	39,890		14.00
15.00	01500	PHARMACY	0	397	0	787	32,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	148	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,859	2,693	29,886	2,708	0	30.00
46.00	04600	OTHER LONG TERM CARE	37,724	2,473	0	688	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	835	7,576	3,913	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	352	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,426	0	581	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,077	0	14,767	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	317	2,765	129	0	65.00
66.00	06600	PHYSICAL THERAPY	0	722	0	268	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	317	0	42	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	125	0	63	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	165	1,838	44	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,101	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,887	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	32,980	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	108	0	76.01
76.03	03950	WOUND CARE	0	105	0	203	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,114	0	782	0	88.00
91.00	09100	EMERGENCY	0	2,049	23,490	4,296	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,119	15,107	65,555	39,867	32,980	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	148	0	18	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	5	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	2,281	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,119	17,536	65,555	39,890	32,980	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,315				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,124	226,721	0	226,721	30.00
46.00	04600	OTHER LONG TERM CARE	229	184,912	0	184,912	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,137	100,999	0	100,999	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	227	5,965	0	5,965	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,037	167,775	0	167,775	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	3,910	80,875	0	80,875	60.00
65.00	06500	RESPIRATORY THERAPY	94	11,133	0	11,133	65.00
66.00	06600	PHYSICAL THERAPY	753	96,997	0	96,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	193	23,847	0	23,847	67.00
68.00	06800	SPEECH PATHOLOGY	69	4,802	0	4,802	68.00
69.00	06900	ELECTROCARDIOLOGY	453	20,387	0	20,387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257	9,815	0	9,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48	3,788	0	3,788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,736	45,530	0	45,530	73.00
76.00	03610	SLEEP LAB	66	8,511	0	8,511	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	177	23,133	0	23,133	76.01
76.03	03950	WOUND CARE	40	13,353	0	13,353	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	235	80,797	0	80,797	88.00
91.00	09100	EMERGENCY	3,530	168,186	0	168,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,315	1,277,526	0	1,277,526	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,970	0	8,970	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	110,284	0	110,284	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	9,573	0	9,573	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	8,698	0	8,698	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	26,109	0	26,109	194.04
194.05	07955	VACANT SPACE	0	8,957	0	8,957	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	2,281	0	2,281	201.00
202.00		TOTAL (sum lines 118 through 201)	22,315	1,452,398	0	1,452,398	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1342

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5A.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,847					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,938				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780	780	8,150,941			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,901	1,901	36,524	66,606,174		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	18,976	18,976	1,361,285	0	-4,815,449	5.02
7.00	00700	OPERATION OF PLANT	14,337	14,337	286,140	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	1,684	33,406	0	0	8.00
9.00	00900	HOUSEKEEPING	1,287	1,287	254,679	0	0	9.00
10.00	01000	DIETARY	3,180	3,180	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	30,011	11.00
13.00	01300	NURSING ADMINISTRATION	2,768	2,768	457,971	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	1,964	87,745	0	0	14.00
15.00	01500	PHARMACY	1,231	1,231	286,233	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	1,144	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,130	7,130	1,185,566	3,354,816	0	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	5,941	664,514	682,944	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,921	3,921	300,518	3,393,097	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	678,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	6,313	531,555	23,987,048	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	1,747	386,259	11,672,332	0	60.00
65.00	06500	RESPIRATORY THERAPY	263	263	109,677	281,730	0	65.00
66.00	06600	PHYSICAL THERAPY	4,429	4,429	303,595	2,246,656	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,000	1,000	160,676	574,734	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	139	73,570	206,093	0	68.00
69.00	06900	ELECTROCARDIOLOGY	759	759	72,897	1,352,935	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	766,264	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,561	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,183,129	0	73.00
76.00	03610	SLEEP LAB	356	356	0	195,629	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	771	771	0	529,487	0	76.01
76.03	03950	WOUND CARE	614	614	24,240	117,941	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,326	3,326	539,760	701,149	0	88.00
91.00	09100	EMERGENCY	4,543	4,543	931,810	10,537,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,504	90,504	8,088,620	66,606,174	-4,785,438	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	470	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,750	5,750	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	391	62,321	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	455	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	1,368	0	0	0	194.04
194.05	07955	VACANT SPACE	909	0	0	0	0	194.05
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)	966,822	485,576	1,379,996	1,313,362		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.683035	4.907882	0.169305	0.019718		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,381	27,788		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001396	0.000417		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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAU NDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	15,787,267				5.02
7.00	00700	OPERATION OF PLANT	1,336,179	62,942			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,645	1,684	50,382		8.00
9.00	00900	HOUSEKEEPING	398,919	1,287	1,577	59,973	9.00
10.00	01000	DIETARY	626,036	3,180	299	3,180	28,256 10.00
11.00	01100	CAFETERIA	0	0	0	0	6,967 11.00
13.00	01300	NURSING ADMINISTRATION	669,908	2,767	0	2,768	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,876	1,964	0	1,964	0 14.00
15.00	01500	PHARMACY	465,312	1,231	0	1,231	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,559	1,144	0	1,144	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,701,708	7,130	11,159	7,130	6,301 30.00
46.00	04600	OTHER LONG TERM CARE	937,473	5,941	22,273	5,941	14,988 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	603,687	3,921	1,911	3,921	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	288,958	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,528,541	6,313	1,756	6,313	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	1,292,367	1,747	0	1,747	0 60.00
65.00	06500	RESPIRATORY THERAPY	147,551	263	0	263	0 65.00
66.00	06600	PHYSICAL THERAPY	500,831	4,429	2,606	4,429	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	226,619	1,000	0	1,000	0 67.00
68.00	06800	SPEECH PATHOLOGY	98,449	139	0	139	0 68.00
69.00	06900	ELECTROCARDIOLOGY	165,993	759	0	759	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,037	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,905	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	490,014	0	0	0	0 73.00
76.00	03610	SLEEP LAB	94,008	356	0	356	0 76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	459,284	771	0	771	0 76.01
76.03	03950	WOUND CARE	77,102	614	0	614	0 76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	836,036	3,325	371	3,326	0 88.00
91.00	09100	EMERGENCY	2,165,126	4,543	8,430	4,543	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,519,123	54,508	50,382	51,539	28,256 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,858	470	0	470	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,478	5,750	0	5,750	0 192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	110,894	391	0	391	0 194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	7,152	455	0	455	0 194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0 194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	19,960	1,368	0	1,368	0 194.04
194.05	07955	VACANT SPACE	8,802	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,815,449	1,743,742	134,931	560,476	935,609 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.305021	27.703950	2.678159	9.345472	33.111870 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	278,780	233,185	32,052	31,950	71,119 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017659	3.704760	0.636180	0.532740	2.516952 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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	9,148					11.00
13.00	01300	NURSING ADMINISTRATION	583	2,600,468				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192	0	581,102			14.00
15.00	01500	PHARMACY	238	0	11,470	393,110		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,150	0	66,606,174	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,614	1,185,566	39,455	0	3,354,816	30.00
46.00	04600	OTHER LONG TERM CARE	1,483	0	10,025	0	682,944	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	501	300,518	56,997	0	3,393,097	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,126	0	678,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	855	0	8,464	0	23,987,048	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	646	0	215,132	0	11,672,332	60.00
65.00	06500	RESPIRATORY THERAPY	190	109,677	1,881	0	281,730	65.00
66.00	06600	PHYSICAL THERAPY	433	0	3,897	0	2,246,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	190	0	607	0	574,734	67.00
68.00	06800	SPEECH PATHOLOGY	75	0	912	0	206,093	68.00
69.00	06900	ELECTROCARDIOLOGY	99	72,897	636	0	1,352,935	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	103,451	0	766,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	42,055	0	144,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	393,110	5,183,129	73.00
76.00	03610	SLEEP LAB	0	0	0	0	195,629	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,574	0	529,487	76.01
76.03	03950	WOUND CARE	63	0	2,957	0	117,941	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	668	0	11,397	0	701,149	88.00
91.00	09100	EMERGENCY	1,229	931,810	62,576	0	10,537,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,059	2,600,468	580,762	393,110	66,606,174	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	89	0	261	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	79	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	200,679	989,558	259,519	663,193	89,749	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.936926	0.380531	0.446598	1.687042	0.001347	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,536	65,555	39,890	32,980	22,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.667578	0.025209	0.068645	0.083895	0.000335	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 9:16 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,232,144		3,232,144	0	0	30.00	
46.00	04600	OTHER LONG TERM CARE	2,037,392		2,037,392	0	0	46.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,093,585		1,093,585	0	0	50.00	
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	380,298		380,298	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,288,251		2,288,251	0	0	54.00	
54.01	05401	ULTRASOUND	0		0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00	
57.00	05700	CT SCAN	0		0	0	0	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	1,877,264		1,877,264	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	249,423	0	249,423	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	838,931	0	838,931	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	338,005	0	338,005	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	135,958	0	135,958	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	276,762		276,762	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	205,189		205,189	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,579		77,579	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,654		1,309,654	0	0	73.00	
76.00	03610	SLEEP LAB	136,136		136,136	0	0	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	629,356		629,356	0	0	76.01	
76.03	03950	WOUND CARE	126,230		126,230	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	1,235,926		1,235,926	0	0	88.00	
91.00	09100	EMERGENCY	3,440,110		3,440,110	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,094		298,094	0	0	92.00	
200.00		Subtotal (see instructions)	20,206,287	0	20,206,287	0	0	200.00	
201.00		Less Observation Beds	298,094		298,094	0	0	201.00	
202.00		Total (see instructions)	19,908,193	0	19,908,193	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 9:16 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,861,471		2,861,471			30.00
46.00	04600	OTHER LONG TERM CARE	682,944		682,944			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	102,997	3,290,100	3,393,097	0.322297	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	27,604	650,396	678,000	0.560912	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	882,582	23,104,466	23,987,048	0.095395	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,379,060	10,293,272	11,672,332	0.160830	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	212,135	69,595	281,730	0.885326	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	301,460	1,945,196	2,246,656	0.373413	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,276	325,458	574,734	0.588107	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	130,097	75,996	206,093	0.659692	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,191	1,330,744	1,352,935	0.204564	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	437,692	328,572	766,264	0.267778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166	144,395	144,561	0.536652	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,038,351	3,144,778	5,183,129	0.252676	0.000000	73.00
76.00	03610	SLEEP LAB	0	195,629	195,629	0.695889	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	529,487	529,487	1.188615	0.000000	76.01
76.03	03950	WOUND CARE	0	117,941	117,941	1.070281	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	701,149	701,149			88.00
91.00	09100	EMERGENCY	40,568	10,497,061	10,537,629	0.326460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,332	486,013	493,345	0.604230	0.000000	92.00
200.00		Subtotal (see instructions)	9,375,926	57,230,248	66,606,174			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,375,926	57,230,248	66,606,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
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	03610	SLEEP LAB	0.000000			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.03	03950	WOUND CARE	0.000000			76.03
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
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:
8/2/2021 9:16 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 9:16 am

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,861,471		2,861,471			30.00
46.00	04600	OTHER LONG TERM CARE	682,944		682,944			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	102,997	3,290,100	3,393,097	0.322297	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	27,604	650,396	678,000	0.560912	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	882,582	23,104,466	23,987,048	0.095395	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,379,060	10,293,272	11,672,332	0.160830	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	212,135	69,595	281,730	0.885326	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	301,460	1,945,196	2,246,656	0.373413	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,276	325,458	574,734	0.588107	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	130,097	75,996	206,093	0.659692	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,191	1,330,744	1,352,935	0.204564	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	437,692	328,572	766,264	0.267778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166	144,395	144,561	0.536652	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,038,351	3,144,778	5,183,129	0.252676	0.000000	73.00
76.00	03610	SLEEP LAB	0	195,629	195,629	0.695889	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	529,487	529,487	1.188615	0.000000	76.01
76.03	03950	WOUND CARE	0	117,941	117,941	1.070281	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	701,149	701,149	1.762715	0.000000	88.00
91.00	09100	EMERGENCY	40,568	10,497,061	10,537,629	0.326460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,332	486,013	493,345	0.604230	0.000000	92.00
200.00		Subtotal (see instructions)	9,375,926	57,230,248	66,606,174			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,375,926	57,230,248	66,606,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.322297			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.560912			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095395			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.160830			60.00
65.00	06500	RESPIRATORY THERAPY	0.885326			65.00
66.00	06600	PHYSICAL THERAPY	0.373413			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588107			67.00
68.00	06800	SPEECH PATHOLOGY	0.659692			68.00
69.00	06900	ELECTROCARDIOLOGY	0.204564			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267778			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.536652			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252676			73.00
76.00	03610	SLEEP LAB	0.695889			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188615			76.01
76.03	03950	WOUND CARE	1.070281			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.762715			88.00
91.00	09100	EMERGENCY	0.326460			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.604230			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,093,585	100,999	992,586	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	380,298	5,965	374,333	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,288,251	167,775	2,120,476	0	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	1,877,264	80,875	1,796,389	0	0
65.00	06500	RESPIRATORY THERAPY	249,423	11,133	238,290	0	0
66.00	06600	PHYSICAL THERAPY	838,931	96,997	741,934	0	0
67.00	06700	OCCUPATIONAL THERAPY	338,005	23,847	314,158	0	0
68.00	06800	SPEECH PATHOLOGY	135,958	4,802	131,156	0	0
69.00	06900	ELECTROCARDIOLOGY	276,762	20,387	256,375	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	205,189	9,815	195,374	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,579	3,788	73,791	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,654	45,530	1,264,124	0	0
76.00	03610	SLEEP LAB	136,136	8,511	127,625	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	629,356	23,133	606,223	0	0
76.03	03950	WOUND CARE	126,230	13,353	112,877	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,235,926	80,797	1,155,129	0	0
91.00	09100	EMERGENCY	3,440,110	168,186	3,271,924	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,094	20,910	277,184	0	0
200.00		Subtotal (sum of lines 50 thru 199)	14,936,751	886,803	14,049,948	0	0
201.00		Less Observation Beds	298,094	20,910	277,184	0	0
202.00		Total (line 200 minus line 201)	14,638,657	865,893	13,772,764	0	0

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

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,093,585	3,393,097	0.322297	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	380,298	678,000	0.560912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,288,251	23,987,048	0.095395	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,877,264	11,672,332	0.160830	60.00
65.00	06500	RESPIRATORY THERAPY	249,423	281,730	0.885326	65.00
66.00	06600	PHYSICAL THERAPY	838,931	2,246,656	0.373413	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,005	574,734	0.588107	67.00
68.00	06800	SPEECH PATHOLOGY	135,958	206,093	0.659692	68.00
69.00	06900	ELECTROCARDIOLOGY	276,762	1,352,935	0.204564	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	205,189	766,264	0.267778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,579	144,561	0.536652	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,654	5,183,129	0.252676	73.00
76.00	03610	SLEEP LAB	136,136	195,629	0.695889	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	629,356	529,487	1.188615	76.01
76.03	03950	WOUND CARE	126,230	117,941	1.070281	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,235,926	701,149	1.762715	88.00
91.00	09100	EMERGENCY	3,440,110	10,537,629	0.326460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,094	493,345	0.604230	92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,936,751	63,061,759		200.00
201.00		Less Observation Beds	298,094	0		201.00
202.00		Total (line 200 minus line 201)	14,638,657	63,061,759		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Title XVIII		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	100,999	3,393,097	0.029766	32,052	954	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,965	678,000	0.008798	5,784	51	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,775	23,987,048	0.006994	476,639	3,334	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	80,875	11,672,332	0.006929	686,776	4,759	60.00
65.00	06500	RESPIRATORY THERAPY	11,133	281,730	0.039517	112,917	4,462	65.00
66.00	06600	PHYSICAL THERAPY	96,997	2,246,656	0.043174	55,207	2,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,847	574,734	0.041492	31,470	1,306	67.00
68.00	06800	SPEECH PATHOLOGY	4,802	206,093	0.023300	51,021	1,189	68.00
69.00	06900	ELECTROCARDIOLOGY	20,387	1,352,935	0.015069	13,245	200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,815	766,264	0.012809	225,153	2,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,788	144,561	0.026203	82	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,530	5,183,129	0.008784	1,101,556	9,676	73.00
76.00	03610	SLEEP LAB	8,511	195,629	0.043506	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23,133	529,487	0.043689	0	0	76.01
76.03	03950	WOUND CARE	13,353	117,941	0.113218	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	80,797	701,149	0.115235	0	0	88.00
91.00	09100	EMERGENCY	168,186	10,537,629	0.015961	32,875	525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,910	493,345	0.042384	2,177	92	92.00
200.00		Total (lines 50 through 199)	886,803	63,061,759		2,826,954	31,818	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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
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: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,393,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	678,000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,987,048	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,672,332	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	281,730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,246,656	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	574,734	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,093	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,352,935	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	766,264	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,183,129	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	195,629	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	529,487	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	117,941	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	701,149	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	10,537,629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	493,345	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	63,061,759		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	32,052	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	5,784	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	476,639	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	686,776	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	112,917	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	55,207	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	31,470	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	51,021	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	13,245	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	225,153	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	82	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,101,556	0	0	0	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950 WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	32,875	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,177	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,826,954	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 9:16 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.322297	0	966,905	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.560912	0	175,304	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095395	0	7,753,980	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.160830	0	2,978,168	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.885326	0	18,929	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373413	0	618,912	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.588107	0	118,399	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.659692	0	31,802	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204564	0	484,924	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.267778	0	111,692	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.536652	0	22,754	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252676	0	1,422,215	230	0	73.00
76.00	03610	SLEEP LAB	0.695889	0	66,942	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188615	0	489,782	0	0	76.01
76.03	03950	WOUND CARE	1.070281	0	63,486	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.326460	0	3,214,684	467	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.604230	0	235,306	0	0	92.00
200.00		Subtotal (see instructions)		0	18,774,184	697	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	18,774,184	697	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 9:16 am

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	311,631	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	98,330	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	739,691	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	478,979	0		60.00
65.00	06500	RESPIRATORY THERAPY	16,758	0		65.00
66.00	06600	PHYSICAL THERAPY	231,110	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	69,631	0		67.00
68.00	06800	SPEECH PATHOLOGY	20,980	0		68.00
69.00	06900	ELECTROCARDIOLOGY	99,198	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,909	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,211	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	359,360	58		73.00
76.00	03610	SLEEP LAB	46,584	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	582,162	0		76.01
76.03	03950	WOUND CARE	67,948	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,049,466	152		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	142,179	0		92.00
200.00		Subtotal (see instructions)	4,356,127	210		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,356,127	210		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
8/2/2021 9:16 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	226,721	53,072	173,649	1,636	106.14	30.00
200.00	Total (lines 30 through 199)	226,721		173,649	1,636		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	14	1,486				30.00
200.00	Total (lines 30 through 199)	14	1,486				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	100,999	3,393,097	0.029766	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	5,965	678,000	0.008798	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,775	23,987,048	0.006994	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	80,875	11,672,332	0.006929	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,133	281,730	0.039517	0	65.00
66.00	06600	PHYSICAL THERAPY	96,997	2,246,656	0.043174	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,847	574,734	0.041492	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,802	206,093	0.023300	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,387	1,352,935	0.015069	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,815	766,264	0.012809	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,788	144,561	0.026203	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,530	5,183,129	0.008784	0	73.00
76.00	03610	SLEEP LAB	8,511	195,629	0.043506	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	23,133	529,487	0.043689	0	76.01
76.03	03950	WOUND CARE	13,353	117,941	0.113218	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	80,797	701,149	0.115235	0	88.00
91.00	09100	EMERGENCY	168,186	10,537,629	0.015961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,910	493,345	0.042384	0	92.00
200.00		Total (lines 50 through 199)	886,803	63,061,759		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1342		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 8/2/2021 9:16 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	1,636	0.00		14	30.00	
200.00		Total (lines 30 through 199)			0	1,636			14	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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
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: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,393,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	678,000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,987,048	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,672,332	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	281,730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,246,656	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	574,734	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,093	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,352,935	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	766,264	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,183,129	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	195,629	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	529,487	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	117,941	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	701,149	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	10,537,629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	493,345	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	63,061,759		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
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
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 9:16 am
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)			2,136 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,636 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,439 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			500 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			870 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)			346 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,232,144	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		756,590	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,475,554	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,475,554	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)		1,513.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,316,467	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,316,467	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					695,674	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,012,141	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					523,560	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					523,560	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,513.17	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					298,094	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XVIII		Hospital		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	226,721	3,232,144	0.070146	298,094	20,910	90.00
91.00	Nursing School cost	0	3,232,144	0.000000	298,094	0	91.00
92.00	Allied health cost	0	3,232,144	0.000000	298,094	0	92.00
93.00	All other Medical Education	0	3,232,144	0.000000	298,094	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 9:16 am	
Cost Center Description		Title XIX	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,636	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,439	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			500	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			14	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,232,144	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			756,590	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,475,554	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,475,554	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)			1,513.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			21,184	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)			21,184	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,184	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,486	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,486	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,698	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,513.17	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					298,094	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	226,721	3,232,144	0.070146	298,094	20,910
91.00	Nursing School cost	0	3,232,144	0.000000	298,094	0
92.00	Allied health cost	0	3,232,144	0.000000	298,094	0
93.00	All other Medical Education	0	3,232,144	0.000000	298,094	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 9:16 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,333,864		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.322297	32,052	10,330	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.560912	5,784	3,244	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.095395	476,639	45,469	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.160830	686,776	110,454	60.00
65.00	06500 RESPIRATORY THERAPY	0.885326	112,917	99,968	65.00
66.00	06600 PHYSICAL THERAPY	0.373413	55,207	20,615	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.588107	31,470	18,508	67.00
68.00	06800 SPEECH PATHOLOGY	0.659692	51,021	33,658	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204564	13,245	2,709	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.267778	225,153	60,291	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.536652	82	44	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252676	1,101,556	278,337	73.00
76.00	03610 SLEEP LAB	0.695889	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188615	0	0	76.01
76.03	03950 WOUND CARE	1.070281	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.326460	32,875	10,732	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.604230	2,177	1,315	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,826,954	695,674	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,826,954		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342 Component CCN: 14-Z342	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 9:16 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.322297	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.560912	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.095395	24,585	2,345	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.160830	124,753	20,064	60.00
65.00	06500 RESPIRATORY THERAPY	0.885326	24,967	22,104	65.00
66.00	06600 PHYSICAL THERAPY	0.373413	152,225	56,843	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.588107	132,980	78,206	67.00
68.00	06800 SPEECH PATHOLOGY	0.659692	43,155	28,469	68.00
69.00	06900 ELECTROCARDIOLOGY	0.204564	1,848	378	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.267778	35,519	9,511	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.536652	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252676	165,675	41,862	73.00
76.00	03610 SLEEP LAB	0.695889	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188615	0	0	76.01
76.03	03950 WOUND CARE	1.070281	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.326460	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.604230	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		705,707	259,782	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)		705,707		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 9:16 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,356,337	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)		4,356,337	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)		4,399,900	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)		58,540	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,078,066	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)		1,263,294	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)		1,263,294	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,263,294	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)		963,751	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		626,438	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		521,485	36.00
37.00	Subtotal (see instructions)		1,889,732	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)		1,889,732	40.00
40.01	Sequestration adjustment (see instructions)		12,472	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		991,258	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)		886,002	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/2/2021 9:16 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,241,102		644,658	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	11/30/2020	118,600	11/30/2020	346,600	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		118,600		346,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,359,702		991,258	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		488,372		886,002	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,848,074		1,877,260	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1342

Period:

Worksheet E-1

Component CCN: 14-Z342

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
8/2/2021 9:16 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		533,072		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	11/30/2020	69,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		69,100		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)		602,172		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		178,013		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		780,185		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: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
8/2/2021 9:16 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2	
		Component CCN: 14-Z342		Date/Time Prepared: 8/2/2021 9:16 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		528,796	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		262,380	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		346	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)		791,176	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		791,176	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)		791,176	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,808	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		785,368	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		785,368	0	19.00
19.01	Sequestration adjustment (see instructions)		5,183	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		602,172	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)		178,013	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/2/2021 9:16 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,012,141	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,012,141	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,032,262	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,032,262	19.00
20.00	Deductibles (exclude professional component)		228,052	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,804,210	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,804,210	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		86,373	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		56,142	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		61,970	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,860,352	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)		1,860,352	30.00
30.01	Sequestration adjustment (see instructions)		12,278	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		1,359,702	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)		488,372	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: 14-1342

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

Worksheet G

Date/Time Prepared:
8/2/2021 9:16 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-119,870	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	5,357,007	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,739,594	0	0	0	6.00
7.00	Inventory	494,393	0	0	0	7.00
8.00	Prepaid expenses	195,525	0	0	0	8.00
9.00	Other current assets	22,327	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,209,788	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	61,877	0	0	0	13.00
14.00	Accumulated depreciation	-1,821	0	0	0	14.00
15.00	Buildings	2,223,328	0	0	0	15.00
16.00	Accumulated depreciation	-68,061	0	0	0	16.00
17.00	Leasehold improvements	3,380,872	0	0	0	17.00
18.00	Accumulated depreciation	-152,103	0	0	0	18.00
19.00	Fixed equipment	549,818	0	0	0	19.00
20.00	Accumulated depreciation	-29,399	0	0	0	20.00
21.00	Automobiles and trucks	6,317	0	0	0	21.00
22.00	Accumulated depreciation	-1,579	0	0	0	22.00
23.00	Major movable equipment	1,829,812	0	0	0	23.00
24.00	Accumulated depreciation	-162,856	0	0	0	24.00
25.00	Minor equipment depreciable	460,966	0	0	0	25.00
26.00	Accumulated depreciation	-75,485	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)	8,021,686	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	1,195,806	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,195,806	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,427,280	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,661,390	0	0	0	37.00
38.00	Salaries, wages, and fees payable	872,365	0	0	0	38.00
39.00	Payroll taxes payable	314,833	0	0	0	39.00
40.00	Notes and loans payable (short term)	66,429	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	10,469,105	0	0	0	43.00
44.00	Other current liabilities	172,832	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,556,954	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,556,954	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-129,674	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-129,674	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,427,280	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1342

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

Worksheet G-1

Date/Time Prepared:
8/2/2021 9:16 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,307,799		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-335,679				2.00
3.00	Total (sum of line 1 and line 2)		23,972,120		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)		23,972,120		0		11.00
12.00	ADJ DUE TO CORPORATE REORGANIZATION	24,101,794		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)		24,101,794		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-129,674		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	ADJ DUE TO CORPORATE REORGANIZATION		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: 14-1342

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/2/2021 9:16 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,861,471		2,861,471	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	682,944		682,944	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,544,415		3,544,415	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,544,415		3,544,415	17.00
18.00	Ancillary services	5,831,511		5,831,511	18.00
19.00	Outpatient services	0	56,529,099	56,529,099	19.00
20.00	RURAL HEALTH CLINIC	0	701,149	701,149	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,375,926	57,230,248	66,606,174	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,394,190		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,394,190		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1342

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

Worksheet G-3

Date/Time Prepared:
8/2/2021 9:16 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,606,174	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,007,773	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,598,401	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,394,190	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,795,789	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	30,011	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	518	17.00
18.00	Revenue from sale of medical records and abstracts	200	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	20,927	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS AND MISCELLANEOUS INCOME	219,950	24.00
24.50	COVID-19 PHE Funding	3,214,577	24.50
25.00	Total other income (sum of lines 6-24)	3,486,183	25.00
26.00	Total (line 5 plus line 25)	-309,606	26.00
27.00	LOSS ON SALE OF ASSETS	26,073	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	26,073	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-335,679	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

From 01/01/2020
To 12/31/2020Date/Time Prepared:
8/2/2021 9:16 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	299,437	0	299,437	0	299,437
3.00	Nurse Practitioner	60,439	0	60,439	0	60,439
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	179,884	0	179,884	0	179,884
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	539,760	0	539,760	0	539,760
11.00	Physician Services Under Agreement	0	77,800	77,800	0	77,800
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	77,800	77,800	0	77,800
15.00	Medical Supplies	0	11,397	11,397	0	11,397
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	11,397	11,397	0	11,397
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	539,760	89,197	628,957	0	628,957
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,138	1,138	0	1,138
30.00	Administrative Costs	36,249	323,149	359,398	-36,249	323,149
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,249	324,287	360,536	-36,249	324,287
32.00	Total facility costs (sum of lines 22, 28 and 31)	576,009	413,484	989,493	-36,249	953,244

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

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

Date/Time Prepared:

8/2/2021 9:16 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	299,437	2.00
3.00	Nurse Practitioner	0	60,439	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	179,884	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	539,760	10.00
11.00	Physician Services Under Agreement	0	77,800	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	77,800	14.00
15.00	Medical Supplies	0	11,397	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	11,397	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	628,957	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,138	29.00
30.00	Administrative Costs	-270,947	52,202	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-270,947	53,340	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-270,947	682,297	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1342 Component CCN: 14-3975		Period: From 01/01/2020 To 12/31/2020		Worksheet M-2 Date/Time Prepared: 8/2/2021 9:16 am	
			RHC I		Cost			
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.00	0	1	0		1.00	
2.00	Physician Assistant	2.47	4,656	1	2		2.00	
3.00	Nurse Practitioner	0.48	308	1	0		3.00	
4.00	Subtotal (sum of lines 1 through 3)	2.95	4,964		2	4,964	4.00	
5.00	Visiting Nurse	0.00	0			0	5.00	
6.00	Clinical Psychologist	0.00	0			0	6.00	
7.00	Clinical Social Worker	0.00	0			0	7.00	
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02	
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.95	4,964			4,964	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)					628,957	10.00	
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00	
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					628,957	12.00	
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00	
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					53,340	14.00	
15.00	Parent provider overhead allocated to facility (see instructions)					553,629	15.00	
16.00	Total overhead (sum of lines 14 and 15)					606,969	16.00	
17.00	Allowable GME overhead (see instructions)					0	17.00	
18.00	Enter the amount from line 16					606,969	18.00	
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					606,969	19.00	
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,235,926	20.00	

Health Financial Systems		UNION COUNTY HOSPITAL DISTRICT		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1342	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-3975		Date/Time Prepared: 8/2/2021 9:16 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,235,926	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,809	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,230,117	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,964	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)			4,964	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			247.81	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		247.81	247.81	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	537	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	133,074	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	133,074	16.00
16.01	Total program charges (see instructions)(from contractor's records)			83,301	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			480	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			767	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.)			89,871	16.04
16.05	Total program cost (see instructions)		0	90,638	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			19,968	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			12,375	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			90,638	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,971	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			92,609	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			92,609	26.00
26.01	Sequestration adjustment (see instructions)			611	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			54,874	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)			37,124	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: 14-1342 Component CCN: 14-3975	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 9:16 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		539,760	539,760	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.001132	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	611	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	2,345	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	2,956	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		628,957	628,957	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		606,969	606,969	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.004700	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	2,853	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	5,809	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	56	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	103.73	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	19	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	1,971	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)			5,809	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)			1,971	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 9:16 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			54,874	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			54,874	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			37,124	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			91,998	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00