

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
11/23/2021 10:59 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/23/2021	Time: 10:59 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 ST. JOSEPHS HOSPITAL (14-0145) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	185,826	40,314	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-97,518		0	10.00
200.00	Total	0	185,826	-57,204	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: 14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:59 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 9515 HOLY CROSS LANE			PO Box:				1.00		
2.00	City: BREESE			State: IL		Zip Code: 62230		County: CLINTON		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST. JOSEPHS HOSPITAL	140145	41180	1	07/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ST. JOSEPHS HOSPITAL	14U145	41180		05/18/2019	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		ST. JOSEPH'S HOSPITAL RHC	148503	41180		01/01/2009	N	O	N
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)						07/01/2020	06/30/2021		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? 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.									22.04
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.					1	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:59 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	237	95	0	2	599	61	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0145

Period:
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To 06/30/2021Worksheet S-2
Part I
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11/23/2021 10:59 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:59 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
				Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			104,706	217	505,302	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:59 am	
				1.00			2.00		
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		148005		140.00	
				1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEMS		Contractor's Name: NGS		Contractor's Number: 00131		141.00		
142.00	Street: 4936 LAVERNA ROAD		PO Box:				142.00		
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62794		143.00		
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A		Part B		Title V	
				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			N		N		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		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		165.00	
				Name		County		State	
				0		1.00		2.00	
						3.00		4.00	
								5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 10:59 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 10:59 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 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)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/05/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				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.	PATTY		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	46	16,790	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		46	16,790	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		46	16,790	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		46				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: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 10:59 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,430	106	3,289		1.00
2.00	HMO and other (see instructions)	344	696			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	792	0	1,221		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	160		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,222	106	4,670		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		131	1,264		13.00
14.00	Total (see instructions)	2,222	237	5,934	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			29		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	11,065	3,760	39,366	0.00	16.91
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	186.06
28.00	Observation Bed Days		42	495		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			120		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	61	194		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: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 10:59 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	346	18	1,179	1.00
2.00	HMO and other (see instructions)			94	157		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	346	18	1,179	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 10:59 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	12,554,870	1,549	12,556,419	358,023.38	35.07 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		123,515	0	123,515	4,252.48	29.05 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		151,621	3,382	155,003	7,222.66	21.46 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		33,543	0	33,543	358.08	93.67 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		146,630	0	146,630	1,147.66	127.76 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		2,738,004	0	2,738,004	68,826.68	39.78 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,842,566	0	4,842,566		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		84,146	0	84,146		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		54,909	0	54,909		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,110,439	0	1,110,439		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 10:59 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,055,289	-27,693	1,027,596	29,661.15	34.64	27.00
28.00	Administrative & General under contract (see inst.)		244,186	0	244,186	1,331.35	183.41	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	464,938	0	464,938	14,411.00	32.26	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	392,409	0	392,409	24,215.69	16.20	32.00
33.00	Housekeeping under contract (see instructions)		236,416	0	236,416	686.40	344.43	33.00
34.00	Dietary	10.00	225,029	-158,510	66,519	4,165.26	15.97	34.00
35.00	Dietary under contract (see instructions)		84,518	0	84,518	2,079.96	40.63	35.00
36.00	Cafeteria	11.00	0	158,510	158,510	9,925.61	15.97	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	880,403	3,662	884,065	13,364.50	66.15	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	375,950	0	375,950	5,700.75	65.95	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	67,642	-3,382	64,260	1,981.27	32.43	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/23/2021 10:59 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	12,996,475	1,549	12,998,024	357,868.61	36.32	1.00
2.00	Excluded area salaries (see instructions)	151,621	3,382	155,003	7,222.66	21.46	2.00
3.00	Subtotal salaries (line 1 minus line 2)	12,844,854	-1,833	12,843,021	350,645.95	36.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,918,177	0	2,918,177	70,332.42	41.49	4.00
5.00	Subtotal wage-related costs (see inst.)	5,953,005	0	5,953,005	0.00	46.35	5.00
6.00	Total (sum of lines 3 thru 5)	21,716,036	-1,833	21,714,203	420,978.37	51.58	6.00
7.00	Total overhead cost (see instructions)	4,026,780	-27,413	3,999,367	107,522.94	37.20	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 10:59 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		60,719	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		1,766,563	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		2,576,275	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		16,900	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		279,131	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		682,685	17.00
18.00	Medicare Taxes - Employers Portion Only		182,041	18.00
19.00	Unemployment Insurance		-619,886	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		37,193	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		4,981,621	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	598,663	4,981,621	1.00
2.00	Hospital	598,663	4,981,621	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0145 Component CCN: 14-8503		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 11/23/2021 10:59 am	
		RHC I		Cost			
		1.00					
1.00	Clinic Address and Identification						
	Street	VARIOUS					
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	VARIOUS		IL	62230	2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)	4.00					
5.00	Migrant Health Center (Section 329(d), PHS Act)	5.00					
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	6.00					
7.00	Appalachian Regional Commission	7.00					
8.00	Look-Alikes	8.00					
9.00	OTHER (SPECIFY)	9.00					
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1)						
	CLINIC		07:00	18:00	07:00	11.00	
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		6		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	ST. JOSEPH'S HOSPITAL		148503		14.00	
14.01		ST. JOSEPH'S HOSPITAL		148502		14.01	
14.02		CLINTON COUNTY RURAL HEALTH		148552		14.02	
14.03		TRENTON					
14.04		CLINTON CNTY RURAL HEALTH		148553		14.03	
14.05		NEW BADEN					
14.06		CLINTON CTY RURAL HEALTH		148554		14.04	
14.07		CARLYLE-BU					
14.08		CLINTON CNTY RURAL HLTH-		148570		14.05	
14.09		CARLYLE RIV					
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	15.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0145

Period:

Worksheet S-8

Component CCN: 14-8503

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 am

RHC I

Cost

		County				
		4.00				
2.00	City, State, ZIP Code, County	VARIOUS				2.00
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
		Facility hours of operations (1)				
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
		Facility hours of operations (1)				
11.00	CLINIC	07:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 10:59 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)			0.279741 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	14,318,349		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	84,092,482		6.00
7.00	Medicaid cost (line 1 times line 6)	23,524,115		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)	9,205,766		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)	9,205,766		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)	1,281,919	593,822	1,875,741 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	358,605	593,822	952,427 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)	358,605	593,822	952,427 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,237,198		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	193,203		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	297,236		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,939,962		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	646,720		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,599,147		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,804,913		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		975,115	975,115	77,115	1,052,230	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	750,908	750,908	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,520,691	4,520,691	-1,492	4,519,199	4.00
5.01	00540	NONPATIENT TELEPHONES	0	61,851	61,851	56,510	118,361	5.01
5.02	00550	DATA PROCESSING	0	1,924,256	1,924,256	-107,690	1,816,566	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	114,489	133,839	248,328	0	248,328	5.03
5.04	00570	ADMITTING	-1,581	1,867	286	-1,791	-1,505	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	ADMIN & GENERAL	942,381	8,116,323	9,058,704	-37,006	9,021,698	5.06
7.00	00700	OPERATION OF PLANT	464,938	1,670,687	2,135,625	60,387	2,196,012	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,663	144,663	0	144,663	8.00
9.00	00900	HOUSEKEEPING	392,409	356,080	748,489	-1,036	747,453	9.00
10.00	01000	DIETARY	225,029	303,902	528,931	-373,971	154,960	10.00
11.00	01100	CAFETERIA	0	0	0	369,054	369,054	11.00
13.00	01300	NURSING ADMINISTRATION	880,403	91,020	971,423	2,064	973,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	375,950	896,235	1,272,185	-713,019	559,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,834	4,834	-364	4,470	16.00
17.00	01700	SOCIAL SERVICE	67,642	1,233	68,875	-4,027	64,848	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,787,062	517,896	3,304,958	-1,651,196	1,653,762	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	183,436	183,436	303,460	486,896	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,239,983	2,162,474	3,402,457	-1,404,510	1,997,947	50.00
51.00	05100	RECOVERY ROOM	2,250	495	2,745	9,453	12,198	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	829	24,393	25,222	1,008,908	1,034,130	52.00
53.00	05300	ANESTHESIOLOGY	0	62,065	62,065	-10,676	51,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,034	470,336	1,379,370	-198,784	1,180,586	54.00
57.00	05700	CT SCAN	418	136,799	137,217	-42,915	94,302	57.00
58.00	05800	MRI	74,432	72,839	147,271	-1,339	145,932	58.00
60.00	06000	LABORATORY	878,958	1,600,982	2,479,940	-33,751	2,446,189	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	83,565	83,565	0	83,565	63.00
65.00	06500	RESPIRATORY THERAPY	400,475	141,230	541,705	-121,279	420,426	65.00
66.00	06600	PHYSICAL THERAPY	1,355,243	201,318	1,556,561	-105,984	1,450,577	66.00
69.00	06900	ELECTROCARDIOLOGY	11,626	44,317	55,943	-10,268	45,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,513	6,513	-6,513	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	73,136	24,308	97,444	1,321,739	1,419,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	609,337	609,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	717,187	717,187	73.00
76.97	07697	CARDIAC REHABILITATION	70,230	6,889	77,119	-3,567	73,552	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	202,618	8,040,975	8,243,593	-103,964	8,139,629	88.00
91.00	09100	EMERGENCY	935,295	1,167,870	2,103,165	-102,433	2,000,732	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	4,140	4,140	-4,078	62	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		216,450	216,450	0	216,450	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,403,249	34,371,886	46,775,135	244,469	47,019,604	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	151,621	4,168,990	4,320,611	-243,173	4,077,438	192.00
194.00	07950	LIFELINE	0	0	0	3,382	3,382	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	15,019	15,019	-4,678	10,341	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	12,554,870	38,555,895	51,110,765	0	51,110,765	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/23/2021 10:59 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	788,964	1,841,194	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	110,379	861,287	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-761,474	3,757,725	4.00
5.01	00540	NONPATIENT TELEPHONES	0	118,361	5.01
5.02	00550	DATA PROCESSING	1,009,759	2,826,325	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	248,328	5.03
5.04	00570	ADMITTING	302,508	301,003	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	553,708	553,708	5.05
5.06	00590	ADMIN & GENERAL	-5,123,527	3,898,171	5.06
7.00	00700	OPERATION OF PLANT	-5,895	2,190,117	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-46,790	97,873	8.00
9.00	00900	HOUSEKEEPING	0	747,453	9.00
10.00	01000	DIETARY	0	154,960	10.00
11.00	01100	CAFETERIA	-4,270	364,784	11.00
13.00	01300	NURSING ADMINISTRATION	-19,660	953,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-2,009	557,157	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	549,240	553,710	16.00
17.00	01700	SOCIAL SERVICE	0	64,848	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,812	1,650,950	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	-170,829	316,067	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-361,240	1,636,707	50.00
51.00	05100	RECOVERY ROOM	0	12,198	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,034,130	52.00
53.00	05300	ANESTHESIOLOGY	0	51,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,180,586	54.00
57.00	05700	CT SCAN	0	94,302	57.00
58.00	05800	MRI	0	145,932	58.00
60.00	06000	LABORATORY	-352,868	2,093,321	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	83,565	63.00
65.00	06500	RESPIRATORY THERAPY	-3,078	417,348	65.00
66.00	06600	PHYSICAL THERAPY	-27,993	1,422,584	66.00
69.00	06900	ELECTROCARDIOLOGY	-15,071	30,604	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,419,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	609,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	717,187	73.00
76.97	07697	CARDIAC REHABILITATION	-1,502	72,050	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	481,396	8,621,025	88.00
91.00	09100	EMERGENCY	-1,056,436	944,296	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	62	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-216,450	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,375,950	42,643,654	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	-27,027	4,050,411	192.00
194.00	07950	LIFELINE	0	3,382	194.00
194.01	07951	DEVELOPMENT	0	0	194.01
194.02	07952	VACANT SPACE	0	10,341	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,402,977	46,707,788	200.00

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/23/2021 10:59 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - TO RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	158,510	210,544		1.00
	0		158,510	210,544		
	C - TO RECLASS MANAGERS SALARY					
1.00	NURSERY	43.00	20,903	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	20,903	0		2.00
3.00	RECOVERY ROOM	51.00	9,853	0		3.00
4.00	ANESTHESIOLOGY	53.00	4,927	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	9,853	0		5.00
	0		66,439	0		
	D - RECLASS SOCIAL SERV SLRY TO LIFELIN					
1.00	LIFELINE	194.00	3,382	0		1.00
	0		3,382	0		
	E - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	717,127		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
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	717,127		
	F - PLANT OP RECLASS					
1.00	OPERATION OF PLANT	7.00	0	121,846		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
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	0		0	121,846		
	G - TELEPHONE RECLASS					
1.00	NONPATIENT TELEPHONES	5.01	0	56,672		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
5.00		0.00	0	0		5.00
	0		0	56,672		
	I - IMPLANTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,317,716		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	609,337		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	1,927,053		
	J - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	77,115		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	750,908		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
7.00	0.00	0	0			7.00
8.00	0.00	0	0			8.00
9.00	0.00	0	0			9.00
10.00	0.00	0	0			10.00
11.00	0.00	0	0			11.00
12.00	0.00	0	0			12.00
13.00	0.00	0	0			13.00
14.00	0.00	0	0			14.00
15.00	0.00	0	0			15.00
16.00	0.00	0	0			16.00
17.00	0.00	0	0			17.00
18.00	0.00	0	0			18.00
19.00	0.00	0	0			19.00
20.00	0.00	0	0			20.00
21.00	0.00	0	0			21.00
22.00	0.00	0	0			22.00
23.00	0.00	0	0			23.00
24.00	0.00	0	0			24.00
25.00	0.00	0	0			25.00
26.00	0.00	0	0			26.00
27.00	0.00	0	0			27.00
28.00	0.00	0	0			28.00
29.00	0.00	0	0			29.00
30.00	0.00	0	0			30.00
0					828,023	
L - SALARY CORRECTION RECLASS						
1.00	NURSERY	43.00	292,118	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,009,005	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	6,513		3.00
0					1,301,123	6,513
N - COVID EXPENSES						
1.00	ADMITTING	5.04	32	0		1.00
2.00	NURSING ADMINISTRATION	13.00	3,662	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	950	0		3.00
4.00	OPERATING ROOM	50.00	8,682	0		4.00
5.00	LABORATORY	60.00	362	3,294		5.00
6.00	PHYSICAL THERAPY	66.00	15,586	0		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	39		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	60		8.00
0					29,274	3,393
P - ADMITTING NEGATIVE SALARIES						
1.00	ADMITTING	5.04	1,549	0		1.00
TOTALS					1,549	0
500.00	Grand Total: Increases		1,560,277	3,871,171		500.00

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/23/2021 10:59 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	B - TO RECLASS CAFETERIA COST						
1.00	DIETARY	10.00	158,510	210,544	0		1.00
	0		158,510	210,544			
	C - TO RECLASS MANAGERS SALARY						
1.00	ADULTS & PEDIATRICS	30.00	41,806	0	0		1.00
2.00	OPERATING ROOM	50.00	24,633	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		66,439	0			
	D - RECLASS SOCIAL SERV SLRY TO LIFELIN						
1.00	SOCIAL SERVICE	17.00	3,382	0	0		1.00
	0		3,382	0			
	E - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	698,880	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,216	0		2.00
3.00	NURSERY	43.00	0	1	0		3.00
4.00	OPERATING ROOM	50.00	0	11,174	0		4.00
5.00	RECOVERY ROOM	51.00	0	71	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	911	0		6.00
7.00	CT SCAN	57.00	0	351	0		7.00
8.00	LABORATORY	60.00	0	379	0		8.00
9.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	507	0		9.00
10.00	EMERGENCY	91.00	0	1,637	0		10.00
	0		0	717,127			
	F - PLANT OP RECLASS						
1.00	PHARMACY	15.00	0	958	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,137	0		2.00
3.00	OPERATING ROOM	50.00	0	767	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	518	0		4.00
5.00	CT SCAN	57.00	0	27	0		5.00
6.00	LABORATORY	60.00	0	529	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	164	0		7.00
8.00	RURAL HEALTH CLINIC	88.00	0	28,759	0		8.00
9.00	EMERGENCY	91.00	0	589	0		9.00
10.00	PHYSICIANS PRIVATE OFFICES	192.00	0	82,720	0		10.00
11.00	VACANT SPACE	194.02	0	4,678	0		11.00
	0		0	121,846			
	G - TELEPHONE RECLASS						
1.00	DATA PROCESSING	5.02	0	3,580	0		1.00
2.00	ADMIN & GENERAL	5.06	0	9	0		2.00
3.00	OPERATION OF PLANT	7.00	0	3,823	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	28,805	0		4.00
5.00	PHYSICIANS PRIVATE OFFICES	192.00	0	20,455	0		5.00
	0		0	56,672			
	I - IMPLANTS RECLASS						
1.00	PHARMACY	15.00	0	9,817	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	25	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	226,728	0		3.00
4.00	NURSERY	43.00	0	4,516	0		4.00
5.00	OPERATING ROOM	50.00	0	1,284,396	0		5.00
6.00	RECOVERY ROOM	51.00	0	329	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,542	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	3,942	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	57,928	0		9.00
10.00	CT SCAN	57.00	0	9,770	0		10.00
11.00	MRI	58.00	0	993	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	117,481	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	114,520	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	4,206	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	1,966	0		15.00
16.00	EMERGENCY	91.00	0	82,391	0		16.00
17.00	PRIORITY CARE CARLYLE	91.01	0	1,503	0		17.00
	0		0	1,927,053			
	J - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,492	9		1.00
2.00	NONPATIENT TELEPHONES	5.01	0	162	9		2.00
3.00	DATA PROCESSING	5.02	0	104,110	0		3.00
4.00	ADMITTING	5.04	0	1,823	0		4.00
5.00	ADMIN & GENERAL	5.06	0	4,330	0		5.00
6.00	OPERATION OF PLANT	7.00	0	57,636	0		6.00
7.00	HOUSEKEEPING	9.00	0	1,036	0		7.00
8.00	DIETARY	10.00	0	4,917	0		8.00

RECLASSIFICATIONS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/23/2021 10:59 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
9.00	NURSING ADMINISTRATION	13.00	0	1,598	0	9.00
10.00	PHARMACY	15.00	0	3,364	0	10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	339	0	11.00
12.00	SOCIAL SERVICE	17.00	0	645	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	77,136	0	13.00
14.00	NURSERY	43.00	0	5,044	0	14.00
15.00	OPERATING ROOM	50.00	0	92,222	0	15.00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,458	0	16.00
17.00	ANESTHESIOLOGY	53.00	0	11,661	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	139,427	0	18.00
19.00	CT SCAN	57.00	0	32,767	0	19.00
20.00	MRI	58.00	0	346	0	20.00
21.00	LABORATORY	60.00	0	36,499	0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	3,798	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	6,886	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	12,575	0	24.00
25.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	5,362	0	25.00
26.00	CARDIAC REHABILITATION	76.97	0	1,601	0	26.00
27.00	RURAL HEALTH CLINIC	88.00	0	46,400	0	27.00
28.00	EMERGENCY	91.00	0	17,816	0	28.00
29.00	PRIORITY CARE CARLYLE	91.01	0	2,575	0	29.00
30.00	PHYSICIANS PRIVATE OFFICES	192.00	0	139,998	0	30.00
			0	828,023		
L - SALARY CORRECTION RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,301,123	0	0	1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,513	0	2.00
3.00		0.00	0	0	0	3.00
			1,301,123	6,513		
N - COVID EXPENSES						
1.00	ADMIN & GENERAL	5.06	29,274	3,393	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
			29,274	3,393		
P - ADMITTING NEGATIVE SALARIES						
1.00	ADMITTING	5.04	0	1,549	0	1.00
	TOTALS		0	1,549		
500.00	Grand Total: Decreases		1,558,728	3,872,720		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 10:59 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,704,211	0	0	0	0	1.00
2.00	Land Improvements	4,755,874	303,921	0	303,921	0	2.00
3.00	Buildings and Fixtures	45,112,333	7,029,028	0	7,029,028	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,923,439	711,094	0	711,094	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,495,857	8,044,043	0	8,044,043	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,495,857	8,044,043	0	8,044,043	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	1,704,211	0				1.00
2.00	Land Improvements	5,059,795	0				2.00
3.00	Buildings and Fixtures	52,141,361	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	27,634,533	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	86,539,900	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	86,539,900	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 10:59 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	975,115	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	975,115	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	975,115				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	975,115				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 10:59 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	58,905,368	0	58,905,368	0.686428	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,634,533	725,556	26,908,977	0.313572	0	2.00
3.00	Total (sum of lines 1-2)	86,539,901	725,556	85,814,345	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	1,841,194	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	861,287	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,702,481	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	0	0	0	1,841,194	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	861,287	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,702,481	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/23/2021 10:59 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 #		
				3.00	4.00		
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)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,099	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,015,222			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	-73,403			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,270	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	B	0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-251	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/23/2021 10:59 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		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST EXPENSE	B	-216,450	INTEREST EXPENSE	113.00	11	33.00
33.01	DEFINED PENSION ADJUSTMENT	A	1,303,559	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-74,409	ADMIN & GENERAL	5.06	0	33.02
33.03	MISCELLANEOUS INCOME	B	-7,850	RURAL HEALTH CLINIC	88.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-1,172	OPERATION OF PLANT	7.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-5	NURSING ADMINISTRATION	13.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-275	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	BANK FEES	B	544	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	LOBBYING EXPENSES	A	-23,408	ADMIN & GENERAL	5.06	0	33.08
33.09	MARKETING & COMMUNITY BENEFIT SALARY	A	-42,165	ADMIN & GENERAL	5.06	0	33.09
35.00	MARKETING & COMMUNITY BENEFIT BENEFI	A	-13,248	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
35.01	MARKETING & COMMUNITY BENEFIT OTHER	A	-128,000	ADMIN & GENERAL	5.06	0	35.01
36.00	MEDICAID PROVIDER TAX	A	-2,040,593	ADMIN & GENERAL	5.06	0	36.00
37.00	ALCOHOL EXPENSE	A	-380	ADMIN & GENERAL	5.06	0	37.00
38.00	NONALLOWABLE EXPENSE	A	-1,850	ADMIN & GENERAL	5.06	0	38.00
39.00	EMPLOYEE SELF-INSURANCE	A	-1,879,446	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	PROPERTY TAX OFFSET	A	-27,027	PHYSICIANS PRIVATE OFFICES	192.00	0	39.01
39.02	PROPERTY TAX OFFSET	A	-20,503	ADMIN & GENERAL	5.06	0	39.02
39.03	BUILDING RELIFING	A	788,964	CAP REL COSTS-BLDG & FIXT	1.00	9	39.03
39.04	EQUIPMENT RELIFING	A	110,379	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.04
40.00	RENTAL INCOME	B	-624	OPERATION OF PLANT	7.00	0	40.00
41.00	NON RHC EXPENSE	A	-14,751	RURAL HEALTH CLINIC	88.00	0	41.00
43.00	NONREIMBURSABLE EXPENSE	A	-355	ADMIN & GENERAL	5.06	0	43.00
44.00	POLITICAL EXPENSE	A	-16,667	ADMIN & GENERAL	5.06	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,402,977				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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:

11/23/2021 10:59 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS - HEALTH &	3,177,402	3,178,152	1.00
2.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS -- ISC M	2,801,207	1,791,448	2.00
3.00	5.05	CASHIERING/ACCOUNTS RECEIVAB	CASHIER/AR SBO	553,708	0	3.00
4.00	5.04	ADMITTING	ADMITTING SBO	302,508	0	4.00
4.01	5.06	ADMIN & GENERAL	ADMIN-SBO	0	2,643,924	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	MED REC-SBO	549,491	0	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS - HUMAN RE	82,247	253,836	4.03
4.04	5.06	ADMIN & GENERAL	ADMIN CONTRACTED SVCS	1,295,433	1,301,485	4.04
4.05	5.06	ADMIN & GENERAL	ADMIN PURCHASED SVCS	0	84,603	4.05
4.06	5.06	ADMIN & GENERAL	IL - A&G	339,593	372,225	4.06
4.07	13.00	NURSING ADMINISTRATION	IL - FLOAT POOL	101,194	101,194	4.07
4.08	60.00	LABORATORY	IL - LAB	904	904	4.08
4.09	15.00	PHARMACY	IL - SHARED PHARMACIST	59,775	61,784	4.09
4.10	8.00	LAUNDRY & LINEN SERVICE	IL - LAUNDRY	66,150	112,940	4.10
4.11	5.06	ADMIN & GENERAL	IL - LIBRARY	14,773	18,746	4.11
4.12	88.00	RURAL HEALTH CLINIC	RHC - MED GROUP MANAGEMENT F	503,453	0	4.12
4.13	5.06	ADMIN & GENERAL	RELATED PARTY TRANSACTIONS	1,526,184	1,526,184	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,374,022	11,447,425	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		
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		100.00	HSBS	0.00	6.00
7.00	G		0.00	HSBS MEDICAL GROUP	0.00	7.00
8.00	G		0.00	ST. ELIZABETH BELLEVILLE	0.00	8.00
9.00	G		0.00	ST. JOHNS HOSPITAL	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	SISTER				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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/23/2021 10:59 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	-750	0		1.00
2.00	1,009,759	0		2.00
3.00	553,708	0		3.00
4.00	302,508	0		4.00
4.01	-2,643,924	0		4.01
4.02	549,491	0		4.02
4.03	-171,589	0		4.03
4.04	-6,052	0		4.04
4.05	-84,603	0		4.05
4.06	-32,632	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	-2,009	0		4.09
4.10	-46,790	0		4.10
4.11	-3,973	0		4.11
4.12	503,453	0		4.12
4.13	0	0		4.13
5.00	-73,403			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	CORPORATE OFFICE		6.00
7.00	PHYSICIAN OFFICES		7.00
8.00	SISTER HOSPITAL		8.00
9.00	SISTER HOSPITAL		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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:

11/23/2021 10:59 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	5.06	ADMIN & GENERAL	4,013	4,013	0	211,500	0	1.00
2.00	13.00	NURSING ADMINISTRATION	19,655	19,655	0	211,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	7,825	0	7,825	211,500	52	3.00
4.00	43.00	NURSERY	170,829	170,829	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	361,240	361,240	0	246,400	0	5.00
6.00	60.00	LABORATORY	443,903	352,868	91,035	260,300	740	6.00
7.00	65.00	RESPIRATORY THERAPY	16,500	0	16,500	211,500	132	7.00
8.00	66.00	PHYSICAL THERAPY	50,770	19,500	31,270	211,500	224	8.00
9.00	69.00	ELECTROCARDIOLOGY	15,071	15,071	0	211,500	0	9.00
10.00	76.97	CARDIAC REHABILITATION	1,502	1,502	0	211,500	0	10.00
11.00	91.00	EMERGENCY	1,056,436	1,056,436	0	211,500	0	11.00
200.00			2,147,744	2,001,114	146,630		1,148	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	5.06	ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	5,288	264	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	92,607	4,630	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	13,422	671	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	22,777	1,139	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			134,094	6,704	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	5.06	ADMIN & GENERAL	0	0	0	4,013		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	19,655		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	5,288	2,537	2,537		3.00
4.00	43.00	NURSERY	0	0	0	170,829		4.00
5.00	50.00	OPERATING ROOM	0	0	0	361,240		5.00
6.00	60.00	LABORATORY	0	92,607	0	352,868		6.00
7.00	65.00	RESPIRATORY THERAPY	0	13,422	3,078	3,078		7.00
8.00	66.00	PHYSICAL THERAPY	0	22,777	8,493	27,993		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	15,071		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	1,502		10.00
11.00	91.00	EMERGENCY	0	0	0	1,056,436		11.00
200.00			0	134,094	14,108	2,015,222		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			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	1,841,194	1,841,194			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	861,287		861,287		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,757,725	3,812	1,631	3,763,168	4.00
5.01	00540	NONPATIENT TELEPHONES	118,361	2,422	177		5.01
5.02	00550	DATA PROCESSING	2,826,325	19,784	148,864		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	248,328	27,657	0	34,312	5.03
5.04	00570	ADMITTING	301,003	30,537	1,993	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	553,708	11,647	0	0	5.05
5.06	00590	ADMIN & GENERAL	3,898,171	472,504	4,358	273,659	5.06
7.00	00700	OPERATION OF PLANT	2,190,117	130,100	62,492	139,342	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,873	31,190	0	0	8.00
9.00	00900	HOUSEKEEPING	747,453	15,389	1,132	117,605	9.00
10.00	01000	DIETARY	154,960	26,220	5,375	19,936	10.00
11.00	01100	CAFETERIA	364,784	16,678	0	47,506	11.00
13.00	01300	NURSING ADMINISTRATION	953,827	5,233	1,536	264,955	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	557,157	8,308	3,994	112,673	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	553,710	10,218	371	0	16.00
17.00	01700	SOCIAL SERVICE	64,848	1,731	705	19,259	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,650,950	122,646	61,341	433,089	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	316,067	7,500	5,513	93,813	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,636,707	145,986	128,152	366,844	50.00
51.00	05100	RECOVERY ROOM	12,198	5,715	0	3,627	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,034,130	25,017	14,120	308,913	52.00
53.00	05300	ANESTHESIOLOGY	51,389	1,506	18,678	1,477	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,586	36,322	191,932	272,438	54.00
57.00	05700	CT SCAN	94,302	3,564	45,499	125	57.00
58.00	05800	MRI	145,932	5,637	378	22,307	58.00
60.00	06000	LABORATORY	2,093,321	17,128	52,030	263,533	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	83,565	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	417,348	8,424	4,621	120,023	65.00
66.00	06600	PHYSICAL THERAPY	1,422,584	96,651	7,874	410,839	66.00
69.00	06900	ELECTROCARDIOLOGY	30,604	0	13,745	3,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,419,183	6,584	5,861	24,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	609,337	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	717,187	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	72,050	15,653	1,694	21,048	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,621,025	213,987	21,297	60,725	88.00
91.00	09100	EMERGENCY	944,296	42,518	22,207	280,309	91.00
91.01	09101	PRIORITY CARE CARLYLE	62	13,844	2,133	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,643,654	1,582,112	829,703	3,716,713	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,050,411	259,082	31,584	45,441	192.00
194.00	07950	LIFELINE	3,382	0	0	1,014	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	194.01
194.02	07952	VACANT SPACE	10,341	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	46,707,788	1,841,194	861,287	3,763,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,001,266					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	311,171				5.03
5.04	00570	ADMITTING	0	3	334,410			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,001,266	0	0	3,566,621		5.05
5.06	00590	ADMIN & GENERAL	0	3,911	0	0	4,666,237	5.06
7.00	00700	OPERATION OF PLANT	0	6,170	0	0	2,532,241	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	129,238	8.00
9.00	00900	HOUSEKEEPING	0	2,639	0	0	885,442	9.00
10.00	01000	DIETARY	0	146	0	0	208,035	10.00
11.00	01100	CAFETERIA	0	0	0	0	428,968	11.00
13.00	01300	NURSING ADMINISTRATION	0	137	0	0	1,226,562	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	164	0	0	683,170	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	569,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	87,592	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,424	10,553	112,575	2,419,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	205	2,954	31,513	457,565	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	12,119	33,148	353,593	2,685,114	50.00
51.00	05100	RECOVERY ROOM	0	6	6,195	66,080	93,821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228	10,204	108,849	1,501,461	52.00
53.00	05300	ANESTHESIOLOGY	0	22	10,874	115,999	200,120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,661	34,994	373,288	2,097,067	54.00
57.00	05700	CT SCAN	0	3,001	43,810	467,326	657,627	57.00
58.00	05800	MRI	0	423	10,522	112,236	297,435	58.00
60.00	06000	LABORATORY	0	12,000	70,822	754,896	3,267,051	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	5,467	1,321	14,088	104,441	63.00
65.00	06500	RESPIRATORY THERAPY	0	145	3,854	41,111	597,449	65.00
66.00	06600	PHYSICAL THERAPY	0	352	16,732	178,478	2,139,978	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,278	4,460	47,573	101,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	121,006	7,285	77,712	1,662,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,021	2,797	29,834	682,989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,282	18,762	200,134	984,365	73.00
76.97	07697	CARDIAC REHABILITATION	0	101	319	3,403	114,967	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	40,993	23,100	246,414	9,227,541	88.00
91.00	09100	EMERGENCY	0	496	21,566	230,047	1,544,585	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	4	138	1,472	17,653	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,001,266	310,404	334,410	3,566,621	42,271,681	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	767	0	0	4,421,370	192.00
194.00	07950	LIFELINE	0	0	0	0	4,396	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	10,341	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,001,266	311,171	334,410	3,566,621	46,707,788	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL	4,666,237					5.06
7.00	00700	OPERATION OF PLANT	281,056	2,813,297				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,344	76,786	220,368			8.00
9.00	00900	HOUSEKEEPING	98,276	37,886	0	1,021,604		9.00
10.00	01000	DIETARY	23,090	64,552	0	0	295,677	10.00
11.00	01100	CAFETERIA	47,612	41,059	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	136,137	12,884	0	5,676	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	75,826	20,453	0	25,540	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,214	25,156	0	5,676	0	16.00
17.00	01700	SOCIAL SERVICE	9,722	4,263	0	5,676	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	268,573	301,944	107,047	198,645	245,983	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	50,786	18,465	0	17,027	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	298,023	359,404	39,976	110,674	0	50.00
51.00	05100	RECOVERY ROOM	10,413	14,069	0	17,027	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,649	61,589	0	11,351	0	52.00
53.00	05300	ANESTHESIOLOGY	22,212	3,708	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,756	89,421	26,159	59,594	29	54.00
57.00	05700	CT SCAN	72,991	8,774	0	11,351	0	57.00
58.00	05800	MRI	33,013	13,878	0	5,676	0	58.00
60.00	06000	LABORATORY	362,613	42,168	0	25,540	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	11,592	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	66,311	20,740	182	11,351	0	65.00
66.00	06600	PHYSICAL THERAPY	237,518	237,946	719	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	11,226	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	184,523	16,210	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,806	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,256	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	12,760	38,536	0	11,351	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,024,177	526,815	738	144,727	0	88.00
91.00	09100	EMERGENCY	171,435	104,675	35,458	90,809	7,860	91.00
91.01	09101	PRIORITY CARE CARLYLE	1,959	34,082	1,039	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,173,869	2,175,463	211,318	757,691	253,872	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	490,732	637,834	9,050	263,913	41,805	192.00
194.00	07950	LIFELINE	488	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	1,148	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,666,237	2,813,297	220,368	1,021,604	295,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
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	517,639					11.00
13.00	01300	NURSING ADMINISTRATION	25,113	1,406,372				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	10,701	46,039	0	861,729		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	663,589	16.00
17.00	01700	SOCIAL SERVICE	3,710	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,640	398,377	0	347	166,445	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	11,131	47,929	0	0	129,214	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,567	269,151	0	0	83,222	50.00
51.00	05100	RECOVERY ROOM	586	2,439	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,907	158,758	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	195	832	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,132	189,849	0	0	66,797	54.00
57.00	05700	CT SCAN	0	16	0	0	0	57.00
58.00	05800	MRI	3,984	17,080	0	0	0	58.00
60.00	06000	LABORATORY	64,832	0	0	0	104,028	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	23,550	0	0	0	8,760	65.00
66.00	06600	PHYSICAL THERAPY	66,667	0	0	0	10,950	66.00
69.00	06900	ELECTROCARDIOLOGY	625	2,633	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,561	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	499,329	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,851	12,194	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,678	50,254	0	361,804	0	88.00
91.00	09100	EMERGENCY	35,657	153,339	0	0	94,173	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	504,087	1,348,890	0	861,480	663,589	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	13,357	57,482	0	249	0	192.00
194.00	07950	LIFELINE	195	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	517,639	1,406,372	0	861,729	663,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	110,963					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	104,823	0	4,304,601	0	4,304,601	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	732,117	0	732,117	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,947	0	3,912,078	0	3,912,078	50.00
51.00	05100	RECOVERY ROOM	0	0	138,355	0	138,355	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,936,715	0	1,936,715	52.00
53.00	05300	ANESTHESIOLOGY	0	0	227,067	0	227,067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,805,804	0	2,805,804	54.00
57.00	05700	CT SCAN	0	0	750,759	0	750,759	57.00
58.00	05800	MRI	0	0	371,066	0	371,066	58.00
60.00	06000	LABORATORY	0	0	3,866,232	0	3,866,232	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	116,033	0	116,033	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	728,343	0	728,343	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,693,778	0	2,693,778	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	115,628	0	115,628	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,869,797	0	1,869,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	758,795	0	758,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,592,950	0	1,592,950	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	192,659	0	192,659	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	11,347,734	0	11,347,734	88.00
91.00	09100	EMERGENCY	2,193	0	2,240,184	0	2,240,184	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	54,733	0	54,733	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,963	0	40,755,428	0	40,755,428	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	5,935,792	0	5,935,792	192.00
194.00	07950	LIFELINE	0	0	5,079	0	5,079	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	11,489	0	11,489	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	110,963	0	46,707,788	0	46,707,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	136	3,812	1,631	5,579	4.00
5.01	00540	NONPATIENT TELEPHONES	0	2,422	177	2,599	5.01
5.02	00550	DATA PROCESSING	620,034	19,784	148,864	788,682	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	85,375	27,657	0	113,032	5.03
5.04	00570	ADMITTING	0	30,537	1,993	32,530	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	24,082	11,647	0	35,729	5.05
5.06	00590	ADMIN & GENERAL	73,113	472,504	4,358	549,975	5.06
7.00	00700	OPERATION OF PLANT	0	130,100	62,492	192,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,190	0	31,190	8.00
9.00	00900	HOUSEKEEPING	0	15,389	1,132	16,521	9.00
10.00	01000	DIETARY	0	26,220	5,375	31,595	10.00
11.00	01100	CAFETERIA	0	16,678	0	16,678	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,233	1,536	6,769	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	8,308	3,994	12,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,218	371	10,589	16.00
17.00	01700	SOCIAL SERVICE	0	1,731	705	2,436	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	596	122,646	61,341	184,583	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	7,500	5,513	13,013	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	97,855	145,986	128,152	371,993	50.00
51.00	05100	RECOVERY ROOM	0	5,715	0	5,715	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,017	14,120	39,137	52.00
53.00	05300	ANESTHESIOLOGY	0	1,506	18,678	20,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,322	191,932	228,254	54.00
57.00	05700	CT SCAN	0	3,564	45,499	49,063	57.00
58.00	05800	MRI	0	5,637	378	6,015	58.00
60.00	06000	LABORATORY	2,881	17,128	52,030	72,039	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,424	4,621	13,045	65.00
66.00	06600	PHYSICAL THERAPY	0	96,651	7,874	104,525	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	13,745	13,745	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	6,584	5,861	12,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	207	0	0	207	73.00
76.97	07697	CARDIAC REHABILITATION	0	15,653	1,694	17,347	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	38,161	213,987	21,297	273,445	88.00
91.00	09100	EMERGENCY	0	42,518	22,207	64,725	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	13,844	2,133	15,977	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	942,440	1,582,112	829,703	3,354,255	5,510
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	259,082	31,584	290,666	192.00
194.00	07950	LIFELINE	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	942,440	1,841,194	861,287	3,644,921	5,579

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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	00540	NONPATIENT TELEPHONES	2,599					5.01
5.02	00550	DATA PROCESSING	135	788,817				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	19	0	113,102			5.03
5.04	00570	ADMITTING	19	0	1	32,550		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	788,817	0	0	824,546	5.05
5.06	00590	ADMIN & GENERAL	293	0	1,422	0	0	5.06
7.00	00700	OPERATION OF PLANT	86	0	2,243	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	26	0	959	0	0	9.00
10.00	01000	DIETARY	30	0	53	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	19	0	50	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	19	0	60	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	23	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	477	0	2,335	1,025	26,027	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	75	287	7,286	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	184	0	4,405	3,221	81,751	50.00
51.00	05100	RECOVERY ROOM	0	0	2	602	15,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	83	992	25,166	52.00
53.00	05300	ANESTHESIOLOGY	4	0	8	1,057	26,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83	0	1,331	3,400	86,304	54.00
57.00	05700	CT SCAN	0	0	1,091	4,257	108,046	57.00
58.00	05800	MRI	0	0	154	1,022	25,949	58.00
60.00	06000	LABORATORY	71	0	4,362	6,938	174,474	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	1,987	128	3,257	63.00
65.00	06500	RESPIRATORY THERAPY	41	0	53	374	9,505	65.00
66.00	06600	PHYSICAL THERAPY	139	0	128	1,626	41,264	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	464	433	10,999	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	43,979	708	17,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	14,910	272	6,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	17,549	1,823	46,271	73.00
76.97	07697	CARDIAC REHABILITATION	15	0	37	31	787	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	14,900	2,245	56,971	88.00
91.00	09100	EMERGENCY	68	0	180	2,096	53,187	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	2	13	340	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,868	788,817	112,823	32,550	824,546	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	731	0	279	0	0	192.00
194.00	07950	LIFELINE	0	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,599	788,817	113,102	32,550	824,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
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To 06/30/2021Worksheet B
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Cost Center Description			ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL	552,095					5.06
7.00	00700	OPERATION OF PLANT	33,253	228,380				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,697	6,233	39,124			8.00
9.00	00900	HOUSEKEEPING	11,628	3,076	0	32,384		9.00
10.00	01000	DIETARY	2,732	5,240	0	0	39,680	10.00
11.00	01100	CAFETERIA	5,633	3,333	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,107	1,046	0	180	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	8,971	1,660	0	810	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,479	2,042	0	180	0	16.00
17.00	01700	SOCIAL SERVICE	1,150	346	0	180	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,777	24,511	19,006	6,297	33,011	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	6,009	1,499	0	540	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,261	29,176	7,097	3,508	0	50.00
51.00	05100	RECOVERY ROOM	1,232	1,142	0	540	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,717	5,000	0	360	0	52.00
53.00	05300	ANESTHESIOLOGY	2,628	301	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,539	7,259	4,644	1,889	4	54.00
57.00	05700	CT SCAN	8,636	712	0	360	0	57.00
58.00	05800	MRI	3,906	1,127	0	180	0	58.00
60.00	06000	LABORATORY	42,903	3,423	0	810	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	1,372	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,846	1,684	32	360	0	65.00
66.00	06600	PHYSICAL THERAPY	28,102	19,316	128	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,328	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	21,832	1,316	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,969	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,927	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,510	3,128	0	360	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	121,181	42,766	131	4,588	0	88.00
91.00	09100	EMERGENCY	20,283	8,497	6,295	2,879	1,055	91.00
91.01	09101	PRIORITY CARE CARLYLE	232	2,767	184	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,840	176,600	37,517	24,021	34,070	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	58,061	51,780	1,607	8,363	5,610	192.00
194.00	07950	LIFELINE	58	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	136	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	552,095	228,380	39,124	32,384	39,680	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
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	25,714					11.00
13.00	01300	NURSING ADMINISTRATION	1,247	25,811				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	532	845	0	25,366		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	20,403	16.00
17.00	01700	SOCIAL SERVICE	184	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,601	7,312	0	10	5,118	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	553	880	0	0	3,973	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,108	4,940	0	0	2,559	50.00
51.00	05100	RECOVERY ROOM	29	45	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,833	2,914	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10	15	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,192	3,484	0	0	2,054	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	198	313	0	0	0	58.00
60.00	06000	LABORATORY	3,221	0	0	0	3,198	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,170	0	0	0	269	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	0	0	337	66.00
69.00	06900	ELECTROCARDIOLOGY	31	48	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	326	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	14,699	0	73.00
76.97	07697	CARDIAC REHABILITATION	142	224	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	580	922	0	10,650	0	88.00
91.00	09100	EMERGENCY	1,771	2,814	0	0	2,895	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,040	24,756	0	25,359	20,403	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	664	1,055	0	7	0	192.00
194.00	07950	LIFELINE	10	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,714	25,811	0	25,366	20,403	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,348					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,107		350,843	0	350,843	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	0		34,254	0	34,254	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	155		547,901	0	547,901	50.00
51.00	05100	RECOVERY ROOM	0		24,590	0	24,590	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		95,660	0	95,660	52.00
53.00	05300	ANESTHESIOLOGY	0		51,028	0	51,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		368,841	0	368,841	54.00
57.00	05700	CT SCAN	0		172,165	0	172,165	57.00
58.00	05800	MRI	0		38,897	0	38,897	58.00
60.00	06000	LABORATORY	0		311,829	0	311,829	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0		6,744	0	6,744	63.00
65.00	06500	RESPIRATORY THERAPY	0		34,557	0	34,557	65.00
66.00	06600	PHYSICAL THERAPY	0		199,486	0	199,486	66.00
69.00	06900	ELECTROCARDIOLOGY	0		27,053	0	27,053	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		98,610	0	98,610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		31,049	0	31,049	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		93,476	0	93,476	73.00
76.97	07697	CARDIAC REHABILITATION	0		23,612	0	23,612	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		528,469	0	528,469	88.00
91.00	09100	EMERGENCY	86		167,246	0	167,246	91.00
91.01	09101	PRIORITY CARE CARLYLE	0		19,515	0	19,515	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,348	0	3,225,825	0	3,225,825	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		418,890	0	418,890	192.00
194.00	07950	LIFELINE	0		70	0	70	194.00
194.01	07951	DEVELOPMENT	0		0	0	0	194.01
194.02	07952	VACANT SPACE	0		136	0	136	194.02
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,348	0	3,644,921	0	3,644,921	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	237,133					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		787,959				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	491	1,492	12,556,419			4.00
5.01	00540	NONPATIENT TELEPHONES	312	162	0	692		5.01
5.02	00550	DATA PROCESSING	2,548	136,190	0	36	100	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	3,562	0	114,489	5	0	5.03
5.04	00570	ADMITTING	3,933	1,823	0	5	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,500	0	0	0	100	5.05
5.06	00590	ADMIN & GENERAL	60,855	3,987	913,107	78	0	5.06
7.00	00700	OPERATION OF PLANT	16,756	57,172	464,938	23	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	0	0	1	0	8.00
9.00	00900	HOUSEKEEPING	1,982	1,036	392,409	7	0	9.00
10.00	01000	DIETARY	3,377	4,917	66,519	8	0	10.00
11.00	01100	CAFETERIA	2,148	0	158,510	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	674	1,405	884,065	5	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,070	3,654	375,950	5	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316	339	0	30	0	16.00
17.00	01700	SOCIAL SERVICE	223	645	64,260	6	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,796	56,119	1,445,083	127	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	966	5,044	313,021	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,802	117,241	1,224,032	49	0	50.00
51.00	05100	RECOVERY ROOM	736	0	12,103	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,222	12,918	1,030,737	0	0	52.00
53.00	05300	ANESTHESIOLOGY	194	17,088	4,927	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,678	175,591	909,034	22	0	54.00
57.00	05700	CT SCAN	459	41,625	418	0	0	57.00
58.00	05800	MRI	726	346	74,432	0	0	58.00
60.00	06000	LABORATORY	2,206	47,600	879,320	19	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,085	4,228	400,475	11	0	65.00
66.00	06600	PHYSICAL THERAPY	12,448	7,204	1,370,829	37	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,575	11,626	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	848	5,362	82,989	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,016	1,550	70,230	4	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	27,560	19,484	202,618	0	0	88.00
91.00	09100	EMERGENCY	5,476	20,316	935,295	18	0	91.00
91.01	09101	PRIORITY CARE CARLYLE	1,783	1,951	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	203,765	759,064	12,401,416	497	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	33,368	28,895	151,621	195	0	192.00
194.00	07950	LIFELINE	0	0	3,382	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,841,194	861,287	3,763,168	120,960	3,001,266	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.764394	1.093061	0.299701	174.797688	30,012.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,579	2,599	788,817	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000444	3.755780	7,888.170000	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description			PURCHASING RECEIVING AND STORES (SUPPLY EXP)	ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliatio n	ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,622,212					5.03
5.04	00570	ADMITTING	44	145,689,642				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	145,689,642			5.05
5.06	00590	ADMIN & GENERAL	58,094	0	0	-4,666,237	42,041,551	5.06
7.00	00700	OPERATION OF PLANT	91,648	0	0	0	2,532,241	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	129,238	8.00
9.00	00900	HOUSEKEEPING	39,203	0	0	0	885,442	9.00
10.00	01000	DIETARY	2,164	0	0	0	208,035	10.00
11.00	01100	CAFETERIA	0	0	0	0	428,968	11.00
13.00	01300	NURSING ADMINISTRATION	2,040	0	0	0	1,226,562	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,435	0	0	0	683,170	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	569,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	87,592	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	95,425	4,598,454	4,598,454	0	2,419,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,046	1,287,246	1,287,246	0	457,565	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	180,023	14,443,571	14,443,571	0	2,685,114	50.00
51.00	05100	RECOVERY ROOM	95	2,699,249	2,699,249	0	93,821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,393	4,446,278	4,446,278	0	1,501,461	52.00
53.00	05300	ANESTHESIOLOGY	322	4,738,334	4,738,334	0	200,120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,383	15,248,081	15,248,081	0	2,097,067	54.00
57.00	05700	CT SCAN	44,576	19,089,331	19,089,331	0	657,627	57.00
58.00	05800	MRI	6,279	4,584,637	4,584,637	0	297,435	58.00
60.00	06000	LABORATORY	178,246	30,836,279	30,836,279	0	3,267,051	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	81,205	575,451	575,451	0	104,441	63.00
65.00	06500	RESPIRATORY THERAPY	2,159	1,679,296	1,679,296	0	597,449	65.00
66.00	06600	PHYSICAL THERAPY	5,230	7,290,475	7,290,475	0	2,139,978	66.00
69.00	06900	ELECTROCARDIOLOGY	18,978	1,943,243	1,943,243	0	101,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,797,456	3,174,362	3,174,362	0	1,662,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	609,337	1,218,675	1,218,675	0	682,989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	717,187	8,175,090	8,175,090	0	984,365	73.00
76.97	07697	CARDIAC REHABILITATION	1,494	139,022	139,022	0	114,967	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	608,919	10,065,505	10,065,505	0	9,227,541	88.00
91.00	09100	EMERGENCY	7,370	9,396,944	9,396,944	0	1,544,585	91.00
91.01	09101	PRIORITY CARE CARLYLE	62	60,119	60,119	0	17,653	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,610,813	145,689,642	145,689,642	-4,666,237	37,605,444	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,399	0	0	0	4,421,370	192.00
194.00	07950	LIFELINE	0	0	0	0	4,396	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	10,341	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	311,171	334,410	3,566,621		4,666,237	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.067321	0.002295	0.024481		0.110991	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,102	32,550	824,546		552,095	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.024469	0.000223	0.005660		0.013132	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	147,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	200,854			8.00
9.00	00900	HOUSEKEEPING	1,982	0	9,000		9.00
10.00	01000	DIETARY	3,377	0	0	20,200	10.00
11.00	01100	CAFETERIA	2,148	0	0	13,254	11.00
13.00	01300	NURSING ADMINISTRATION	674	0	50	643	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	1,070	0	225	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316	0	50	0	16.00
17.00	01700	SOCIAL SERVICE	223	0	50	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,796	97,567	1,750	16,805	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	966	0	150	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,802	36,436	975	0	50.00
51.00	05100	RECOVERY ROOM	736	0	150	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,222	0	100	0	52.00
53.00	05300	ANESTHESIOLOGY	194	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,678	23,843	525	2	54.00
57.00	05700	CT SCAN	459	0	100	0	57.00
58.00	05800	MRI	726	0	50	0	58.00
60.00	06000	LABORATORY	2,206	0	225	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,085	166	100	0	65.00
66.00	06600	PHYSICAL THERAPY	12,448	655	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	848	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,016	0	100	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	27,560	673	1,275	0	88.00
91.00	09100	EMERGENCY	5,476	32,318	800	537	91.00
91.01	09101	PRIORITY CARE CARLYLE	1,783	947	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,808	192,605	6,675	17,344	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	33,368	8,249	2,325	2,856	192.00
194.00	07950	LIFELINE	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,813,297	220,368	1,021,604	295,677	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.115189	1.097155	113.511556	14.637475	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	228,380	39,124	32,384	39,680	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.551748	0.194788	3.598222	1.964356	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description			NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMIN & GENERAL						5.06
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	174,151					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	5,701	0	1,143,810			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	606		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	506	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,331	0	460	152	478	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	5,935	0	0	118	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,329	0	0	76	18	50.00
51.00	05100	RECOVERY ROOM	302	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,659	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	103	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,509	0	0	61	0	54.00
57.00	05700	CT SCAN	2	0	0	0	0	57.00
58.00	05800	MRI	2,115	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	95	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10	0	66.00
69.00	06900	ELECTROCARDIOLOGY	326	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	662,781	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,510	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,223	0	480,238	0	0	88.00
91.00	09100	EMERGENCY	18,988	0	0	86	10	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,033	0	1,143,479	606	506	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	7,118	0	331	0	0	192.00
194.00	07950	LIFELINE	0	0	0	0	0	194.00
194.01	07951	DEVELOPMENT	0	0	0	0	0	194.01
194.02	07952	VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,406,372	0	861,729	663,589	110,963	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.075590	0.000000	0.753385	1,095.031353	219.294466	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,811	0	25,366	20,403	4,348	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.148210	0.000000	0.022177	33.668317	8.592885	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
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	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	ADMIN & GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
91.01	09101	PRIORITY CARE CARLYLE	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	LIFELINE	194.00
194.01	07951	DEVELOPMENT	194.01
194.02	07952	VACANT SPACE	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 10:59 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,304,601		4,304,601	2,537	4,307,138	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	732,117		732,117	0	732,117	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,912,078		3,912,078	0	3,912,078	50.00
51.00	05100	RECOVERY ROOM	138,355		138,355	0	138,355	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,936,715		1,936,715	0	1,936,715	52.00
53.00	05300	ANESTHESIOLOGY	227,067		227,067	0	227,067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,805,804		2,805,804	0	2,805,804	54.00
57.00	05700	CT SCAN	750,759		750,759	0	750,759	57.00
58.00	05800	MRI	371,066		371,066	0	371,066	58.00
60.00	06000	LABORATORY	3,866,232		3,866,232	0	3,866,232	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	116,033		116,033	0	116,033	63.00
65.00	06500	RESPIRATORY THERAPY	728,343	0	728,343	3,078	731,421	65.00
66.00	06600	PHYSICAL THERAPY	2,693,778	0	2,693,778	8,493	2,702,271	66.00
69.00	06900	ELECTROCARDIOLOGY	115,628		115,628	0	115,628	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,869,797		1,869,797	0	1,869,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	758,795		758,795	0	758,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,592,950		1,592,950	0	1,592,950	73.00
76.97	07697	CARDIAC REHABILITATION	192,659		192,659	0	192,659	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,347,734		11,347,734	0	11,347,734	88.00
91.00	09100	EMERGENCY	2,240,184		2,240,184	0	2,240,184	91.00
91.01	09101	PRIORITY CARE CARLYLE	54,733		54,733	0	54,733	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	559,697		559,697		559,697	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,315,125	0	41,315,125	14,108	41,329,233	200.00
201.00		Less Observation Beds	559,697		559,697		559,697	201.00
202.00		Total (see instructions)	40,755,428	0	40,755,428	14,108	40,769,536	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:59 am		
					Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				9.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,877,258		3,877,258			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
43.00	04300	NURSERY	1,287,246		1,287,246			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,309,427	13,134,144	14,443,571	0.270853	0.000000	50.00	
51.00	05100	RECOVERY ROOM	145,556	2,553,693	2,699,249	0.051257	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,765,107	681,171	4,446,278	0.435581	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	1,821,249	2,917,085	4,738,334	0.047921	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	915,146	14,332,935	15,248,081	0.184010	0.000000	54.00	
57.00	05700	CT SCAN	2,204,124	16,885,207	19,089,331	0.039329	0.000000	57.00	
58.00	05800	MRI	184,590	4,400,047	4,584,637	0.080937	0.000000	58.00	
60.00	06000	LABORATORY	4,262,051	26,574,228	30,836,279	0.125379	0.000000	60.00	
63.00	06300	BLOOD STORING PROCESSING & TRA	237,087	338,364	575,451	0.201638	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	848,279	831,017	1,679,296	0.433719	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	924,463	6,366,012	7,290,475	0.369493	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	203,616	1,739,627	1,943,243	0.059503	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	883,936	2,290,426	3,174,362	0.589031	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	303,000	915,675	1,218,675	0.622639	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,507,257	5,667,833	8,175,090	0.194854	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	139,022	139,022	1.385817	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,065,505	10,065,505			88.00	
91.00	09100	EMERGENCY	1,142,719	8,254,225	9,396,944	0.238395	0.000000	91.00	
91.01	09101	PRIORITY CARE CARLYLE	55	60,064	60,119	0.910411	0.000000	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	134,530	586,666	721,196	0.776068	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	26,956,696	118,732,946	145,689,642			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	26,956,696	118,732,946	145,689,642			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:59 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.270853			50.00
51.00	05100	RECOVERY ROOM	0.051257			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435581			52.00
53.00	05300	ANESTHESIOLOGY	0.047921			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184010			54.00
57.00	05700	CT SCAN	0.039329			57.00
58.00	05800	MRI	0.080937			58.00
60.00	06000	LABORATORY	0.125379			60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.201638			63.00
65.00	06500	RESPIRATORY THERAPY	0.435552			65.00
66.00	06600	PHYSICAL THERAPY	0.370658			66.00
69.00	06900	ELECTROCARDIOLOGY	0.059503			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.589031			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622639			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194854			73.00
76.97	07697	CARDIAC REHABILITATION	1.385817			76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.238395			91.00
91.01	09101	PRIORITY CARE CARLYLE	0.910411			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.776068			92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2020
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			Title XIX		Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,304,601		4,304,601	2,537	4,307,138	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	732,117		732,117	0	732,117	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,912,078		3,912,078	0	3,912,078	50.00
51.00	05100	RECOVERY ROOM	138,355		138,355	0	138,355	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,936,715		1,936,715	0	1,936,715	52.00
53.00	05300	ANESTHESIOLOGY	227,067		227,067	0	227,067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,805,804		2,805,804	0	2,805,804	54.00
57.00	05700	CT SCAN	750,759		750,759	0	750,759	57.00
58.00	05800	MRI	371,066		371,066	0	371,066	58.00
60.00	06000	LABORATORY	3,866,232		3,866,232	0	3,866,232	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	116,033		116,033	0	116,033	63.00
65.00	06500	RESPIRATORY THERAPY	728,343	0	728,343	3,078	731,421	65.00
66.00	06600	PHYSICAL THERAPY	2,693,778	0	2,693,778	8,493	2,702,271	66.00
69.00	06900	ELECTROCARDIOLOGY	115,628		115,628	0	115,628	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,869,797		1,869,797	0	1,869,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	758,795		758,795	0	758,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,592,950		1,592,950	0	1,592,950	73.00
76.97	07697	CARDIAC REHABILITATION	192,659		192,659	0	192,659	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,347,734		11,347,734	0	11,347,734	88.00
91.00	09100	EMERGENCY	2,240,184		2,240,184	0	2,240,184	91.00
91.01	09101	PRIORITY CARE CARLYLE	54,733		54,733	0	54,733	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	559,697		559,697		559,697	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,315,125	0	41,315,125	14,108	41,329,233	200.00
201.00		Less Observation Beds	559,697		559,697		559,697	201.00
202.00		Total (see instructions)	40,755,428	0	40,755,428	14,108	40,769,536	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/23/2021 10:59 am		
					Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
			9.00			10.00			
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,877,258		3,877,258			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
43.00	04300	NURSERY	1,287,246		1,287,246			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,309,427	13,134,144	14,443,571	0.270853	0.000000	50.00	
51.00	05100	RECOVERY ROOM	145,556	2,553,693	2,699,249	0.051257	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,765,107	681,171	4,446,278	0.435581	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	1,821,249	2,917,085	4,738,334	0.047921	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	915,146	14,332,935	15,248,081	0.184010	0.000000	54.00	
57.00	05700	CT SCAN	2,204,124	16,885,207	19,089,331	0.039329	0.000000	57.00	
58.00	05800	MRI	184,590	4,400,047	4,584,637	0.080937	0.000000	58.00	
60.00	06000	LABORATORY	4,262,051	26,574,228	30,836,279	0.125379	0.000000	60.00	
63.00	06300	BLOOD STORING PROCESSING & TRA	237,087	338,364	575,451	0.201638	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	848,279	831,017	1,679,296	0.433719	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	924,463	6,366,012	7,290,475	0.369493	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	203,616	1,739,627	1,943,243	0.059503	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	883,936	2,290,426	3,174,362	0.589031	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	303,000	915,675	1,218,675	0.622639	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,507,257	5,667,833	8,175,090	0.194854	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	139,022	139,022	1.385817	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,065,505	10,065,505	1.127388	0.000000	88.00	
91.00	09100	EMERGENCY	1,142,719	8,254,225	9,396,944	0.238395	0.000000	91.00	
91.01	09101	PRIORITY CARE CARLYLE	55	60,064	60,119	0.910411	0.000000	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	134,530	586,666	721,196	0.776068	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	26,956,696	118,732,946	145,689,642			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	26,956,696	118,732,946	145,689,642			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
63.00	06300	BLOOD STORING PROCESSING & TRA	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PRIORITY CARE CARLYLE	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/23/2021 10:59 am

			Title XVIII		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	350,843	2,327	348,516	3,784	92.10	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	34,254		34,254	1,264	27.10	43.00
200.00	Total (lines 30 through 199)	385,097		382,770	5,048		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,430	131,703				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	1,430	131,703				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital		PPS	
			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	547,901	14,443,571	0.037934	569,534	21,605	50.00
51.00	05100	RECOVERY ROOM	24,590	2,699,249	0.009110	69,363	632	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	95,660	4,446,278	0.021515	12,223	263	52.00
53.00	05300	ANESTHESIOLOGY	51,028	4,738,334	0.010769	131,281	1,414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,841	15,248,081	0.024189	496,572	12,012	54.00
57.00	05700	CT SCAN	172,165	19,089,331	0.009019	1,277,896	11,525	57.00
58.00	05800	MRI	38,897	4,584,637	0.008484	103,821	881	58.00
60.00	06000	LABORATORY	311,829	30,836,279	0.010112	1,883,484	19,046	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	6,744	575,451	0.011720	48,594	570	63.00
65.00	06500	RESPIRATORY THERAPY	34,557	1,679,296	0.020578	402,353	8,280	65.00
66.00	06600	PHYSICAL THERAPY	199,486	7,290,475	0.027363	185,774	5,083	66.00
69.00	06900	ELECTROCARDIOLOGY	27,053	1,943,243	0.013922	129,809	1,807	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	98,610	3,174,362	0.031065	379,206	11,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,049	1,218,675	0.025478	232,575	5,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,476	8,175,090	0.011434	961,435	10,993	73.00
76.97	07697	CARDIAC REHABILITATION	23,612	139,022	0.169844	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	528,469	10,065,505	0.052503	0	0	88.00
91.00	09100	EMERGENCY	167,246	9,396,944	0.017798	676,296	12,037	91.00
91.01	09101	PRIORITY CARE CARLYLE	19,515	60,119	0.324606	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	45,591	721,196	0.063216	71,477	4,518	92.00
200.00		Total (lines 50 through 199)	2,886,319	140,525,138		7,631,693	128,372	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/23/2021 10:59 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,784	0.00	1,430	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00		
43.00	04300	NURSERY		0	1,264	0.00	0	43.00		
200.00	Total (lines 30 through 199)			0	5,048		1,430	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
43.00	04300	NURSERY	0						43.00	
200.00	Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 10:59 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	14,443,571	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,699,249	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,446,278	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,738,334	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,248,081	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	19,089,331	0.000000	57.00
58.00	05800	MRI	0	0	0	4,584,637	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	30,836,279	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0	0	0	575,451	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,679,296	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,290,475	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,943,243	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,174,362	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,218,675	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,175,090	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	139,022	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	10,065,505	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,396,944	0.000000	91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0	0	60,119	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	721,196	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	140,525,138		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 10:59 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	569,534	0	3,565,647	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	69,363	0	631,020	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	12,223	0	2,471	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	131,281	0	769,164	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	496,572	0	4,147,527	0	54.00
57.00	05700	CT SCAN	0.000000	1,277,896	0	6,568,156	0	57.00
58.00	05800	MRI	0.000000	103,821	0	1,329,110	0	58.00
60.00	06000	LABORATORY	0.000000	1,883,484	0	2,954,892	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.000000	48,594	0	61,437	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	402,353	0	288,647	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	185,774	0	684,350	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	129,809	0	652,393	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	379,206	0	492,521	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	232,575	0	212,771	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	961,435	0	1,804,091	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76,334	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	676,296	0	2,395,886	0	91.00
91.01	09101	PRIORITY CARE CARLYLE	0.000000	0	0	3,059	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	71,477	0	330,312	0	92.00
200.00		Total (lines 50 through 199)		7,631,693	0	26,969,788	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/23/2021 10:59 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.270853	3,565,647	0	0	965,766	50.00
51.00	05100	RECOVERY ROOM	0.051257	631,020	0	0	32,344	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435581	2,471	0	0	1,076	52.00
53.00	05300	ANESTHESIOLOGY	0.047921	769,164	0	0	36,859	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184010	4,147,527	0	0	763,186	54.00
57.00	05700	CT SCAN	0.039329	6,568,156	0	0	258,319	57.00
58.00	05800	MRI	0.080937	1,329,110	0	0	107,574	58.00
60.00	06000	LABORATORY	0.125379	2,954,892	1,167	0	370,481	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.201638	61,437	23	0	12,388	63.00
65.00	06500	RESPIRATORY THERAPY	0.433719	288,647	0	0	125,192	65.00
66.00	06600	PHYSICAL THERAPY	0.369493	684,350	0	0	252,863	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059503	652,393	0	0	38,819	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.589031	492,521	0	0	290,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622639	212,771	0	0	132,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194854	1,804,091	0	10,090	351,534	73.00
76.97	07697	CARDIAC REHABILITATION	1.385817	76,334	0	0	105,785	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.238395	2,395,886	0	0	571,167	91.00
91.01	09101	PRIORITY CARE CARLYLE	0.910411	3,059	0	0	2,785	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.776068	330,312	0	0	256,345	92.00
200.00		Subtotal (see instructions)		26,969,788	1,190	10,090	4,675,073	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		26,969,788	1,190	10,090	4,675,073	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 10:59 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	146	0					60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	5	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,966					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	0	0					91.00
91.01	09101	PRIORITY CARE CARLYLE	0	0					91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0					92.00
200.00		Subtotal (see instructions)	151	1,966					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	151	1,966					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 10:59 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,784	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)		3,289	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		610	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)		611	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		80	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)		80	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,430	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)		291	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)		501	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,307,138	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)		14,287	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)		14,287	25.00
26.00	Total swing-bed cost (see instructions)		28,574	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,278,564	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,278,564	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)		1,130.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,616,901	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)		1,616,901	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,589,451
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,206,352
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					131,703
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					128,372
52.00	Total Program excludable cost (sum of lines 50 and 51)					260,075
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,946,277
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					495
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,130.70
89.00	Observation bed cost (line 87 x line 88) (see instructions)					559,697

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0145		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/23/2021 10:59 am		
				Title XVIII		Hospital		PPS		
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)				
		1.00	2.00	3.00	4.00	5.00				
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	350,843	4,307,138	0.081456	559,697	45,591		90.00		
91.00	Nursing School cost	0	4,307,138	0.000000	559,697	0		91.00		
92.00	Allied health cost	0	4,307,138	0.000000	559,697	0		92.00		
93.00	All other Medical Education	0	4,307,138	0.000000	559,697	0		93.00		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:59 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		1,306,722		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.270853	569,534	154,260	50.00
51.00	05100	RECOVERY ROOM	0.051257	69,363	3,555	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435581	12,223	5,324	52.00
53.00	05300	ANESTHESIOLOGY	0.047921	131,281	6,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184010	496,572	91,374	54.00
57.00	05700	CT SCAN	0.039329	1,277,896	50,258	57.00
58.00	05800	MRI	0.080937	103,821	8,403	58.00
60.00	06000	LABORATORY	0.125379	1,883,484	236,149	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.201638	48,594	9,798	63.00
65.00	06500	RESPIRATORY THERAPY	0.435552	402,353	175,246	65.00
66.00	06600	PHYSICAL THERAPY	0.370658	185,774	68,859	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059503	129,809	7,724	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.589031	379,206	223,364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622639	232,575	144,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194854	961,435	187,339	73.00
76.97	07697	CARDIAC REHABILITATION	1.385817	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.238395	676,296	161,226	91.00
91.01	09101	PRIORITY CARE CARLYLE	0.910411	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.776068	71,477	55,471	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,631,693	1,589,451	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)		7,631,693		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 10:59 am
			Component CCN: 14-U145		
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.270853	0	50.00
51.00	05100	RECOVERY ROOM	0.051257	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435581	0	52.00
53.00	05300	ANESTHESIOLOGY	0.047921	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184010	24,689	54.00
57.00	05700	CT SCAN	0.039329	14,241	57.00
58.00	05800	MRI	0.080937	3,492	58.00
60.00	06000	LABORATORY	0.125379	136,889	60.00
63.00	06300	BLOOD STORING PROCESSING & TRA	0.201638	2,068	63.00
65.00	06500	RESPIRATORY THERAPY	0.435552	47,989	65.00
66.00	06600	PHYSICAL THERAPY	0.370658	327,625	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059503	1,232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.589031	28,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622639	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194854	146,168	73.00
76.97	07697	CARDIAC REHABILITATION	1.385817	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
91.00	09100	EMERGENCY	0.238395	2,629	91.00
91.01	09101	PRIORITY CARE CARLYLE	0.910411	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.776068	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		736,011	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)		736,011	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:59 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		670,821	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,012,464	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		347	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		1,042	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		40.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.42	31.00
32.00	Sum of lines 30 and 31		21.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.08	33.00
34.00	Disproportionate share adjustment (see instructions)		47,495	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:59 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000088404	0.000040816	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		738,225	338,368	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		185,565	253,081	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		438,646		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,170,815		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			3,170,815	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			202,797	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			51,458	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,425,070	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,425,070	61.00
62.00	Deductibles billed to program beneficiaries			383,952	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			99,751	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			64,838	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			90,476	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,105,956	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			38,195	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 10:59 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	185,375	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	487,060	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		30,086	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,786,500	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		3,600,674	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		185,826	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		217,830	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	670,821	0	670,821		670,821
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,012,464	0		2,012,464	2,012,464
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	347	0	347		347
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,042	0		1,042	1,042
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0708	0.0708	0.0708	0.0708	
11.00	Disproportionate share adjustment (see instructions)	34.00	47,495	0	11,874	35,621	47,495
11.01	Uncompensated care payments	36.00	438,646	0	185,565	253,081	438,646
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	3,170,815	0	868,607	2,302,208	3,170,815
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,170,815	0	868,607	2,302,208	3,170,815

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	202,797	0	50,700	152,097	202,797
17.00	Special add-on payments for new technologies	54.00	51,458	0	12,865	38,593	51,458
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	932,172	2,492,898	3,425,070
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	202,431	0	50,608	151,823	202,431
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	366	0	92	274	366
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	202,797	0	50,700	152,097	202,797
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.198864	0.195379	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			185,375		185,375
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				487,060	487,060
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	670,821	670,821		670,821	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,012,464		2,012,464	2,012,464	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	347	347		347	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,042		1,042	1,042	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0708	0.0708	0.0708		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	47,495	11,874	35,621	47,495	11.00
11.01	Uncompensated care payments	36.00	438,646	185,565	253,081	438,646	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,170,815	868,607	2,302,208	3,170,815	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,170,815	868,607	2,302,208	3,170,815	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	202,797	50,700	152,097	202,797	16.00
17.00	Special add-on payments for new technologies	54.00	51,458	12,865	38,593	51,458	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			932,172	2,492,898	3,425,070	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	202,431	50,608	151,823	202,431	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	366	92	274	366	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	202,797	50,700	152,097	202,797	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	185,375	185,375		185,375	28.00
29.00	Low volume adjustment on or after October 1	70.97	487,060		487,060	487,060	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	38,195	9,549	28,646	38,195	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	30,086	30,086	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 10:59 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,117	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,675,073	2.00
3.00	OPPS payments		3,780,147	3.00
4.00	Outlier payment (see instructions)		4,164	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,117	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		11,280	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)		11,280	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		11,280	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,163	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,117	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3,784,311	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		758,682	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,027,746	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,027,746	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,027,746	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)		163,663	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		106,381	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		152,199	36.00
37.00	Subtotal (see instructions)		3,134,127	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,134,127	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,093,813	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)		40,314	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: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,582,527		3,063,422	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	03/17/2021	18,147	03/17/2021	30,391	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)		18,147		30,391	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)		3,600,674		3,093,813	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		185,826		40,314	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,786,500		3,134,127	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: 14-0145

Period:

Worksheet E-1

Component CCN: 14-U145

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		431,321		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		431,321		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		431,321		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/23/2021 10:59 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0145

Period:

Worksheet E-2

Component CCN: 14-U145

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII	Swing Beds - SNF	PPS	
			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)		461,653	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)		0	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		792	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)		461,653	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		461,653	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)		461,653	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		30,332	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		431,321	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)		431,321	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		431,321	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, 19.02, 19.25, 20, and 21)		0	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

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

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/23/2021 10:59 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	1,353,490	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	15,183,250	0	0	0	4.00
5.00	Other receivable	173,490	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,913,780	0	0	0	6.00
7.00	Inventory	781,827	0	0	0	7.00
8.00	Prepaid expenses	123,329	0	0	0	8.00
9.00	Other current assets	7,007,536	0	0	0	9.00
10.00	Due from other funds	-44,352	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,664,790	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,704,211	0	0	0	12.00
13.00	Land improvements	5,059,795	0	0	0	13.00
14.00	Accumulated depreciation	-3,461,396	0	0	0	14.00
15.00	Buildings	31,839,804	0	0	0	15.00
16.00	Accumulated depreciation	-14,965,998	0	0	0	16.00
17.00	Leasehold improvements	267,301	0	0	0	17.00
18.00	Accumulated depreciation	-267,301	0	0	0	18.00
19.00	Fixed equipment	20,034,256	0	0	0	19.00
20.00	Accumulated depreciation	-12,951,621	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	27,634,533	0	0	0	23.00
24.00	Accumulated depreciation	-22,622,503	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,271,081	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	156,829,026	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	5,730,344	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	162,559,370	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	211,495,241	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,619,117	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,946,078	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,044,456	0	0	0	40.00
41.00	Deferred income	5,638,247	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	326,356	0	0	0	43.00
44.00	Other current liabilities	4,748,768	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,323,022	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	13,088,214	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	4,697,328	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,785,542	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,108,564	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	175,386,677	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)	175,386,677	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	211,495,241	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/23/2021 10:59 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		140,532,590		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		39,093,410				2.00
3.00	Total (sum of line 1 and line 2)		179,626,000		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)		179,626,000		0		11.00
12.00	NET TRANSFERS	4,239,323		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)		4,239,323		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		175,386,677		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	NET TRANSFERS		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: 14-0145

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 10:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,270,620		5,270,620	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,270,620		5,270,620	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	5,270,620		5,270,620	17.00
18.00	Ancillary services	20,972,712	102,408,785	123,381,497	18.00
19.00	Outpatient services	1,291,244	9,040,652	10,331,896	19.00
20.00	RURAL HEALTH CLINIC	0	10,065,505	10,065,505	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	PHYSICIANS	33,711	479,741	513,452	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,568,287	121,994,683	149,562,970	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,110,765		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)		51,110,765		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0145

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:

11/23/2021 10:59 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	149,562,970	1.00
2.00	Less contractual allowances and discounts on patients' accounts	91,312,142	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,250,828	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,110,765	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,140,063	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	4,270	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	251	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	435,966	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	26,623,252	24.00
24.50	COVID-19 PHE Funding	4,889,608	24.50
25.00	Total other income (sum of lines 6-24)	31,953,347	25.00
26.00	Total (line 5 plus line 25)	39,093,410	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	39,093,410	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0145	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/23/2021 10:59 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		202,431	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		366	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		9.87	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		202,797	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0145

Period:

Worksheet M-1

Component CCN: 14-8503

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	2,388,544	2,388,544	0	2,388,544
2.00	Physician Assistant	0	178,946	178,946	0	178,946
3.00	Nurse Practitioner	90,551	1,884,523	1,975,074	0	1,975,074
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	32,964	242,919	275,883	0	275,883
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	135,778	135,778	0	135,778
10.00	Subtotal (sum of lines 1 through 9)	123,515	4,830,710	4,954,225	0	4,954,225
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	72,381	72,381	0	72,381
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	493,621	493,621	0	493,621
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	566,002	566,002	0	566,002
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	123,515	5,396,712	5,520,227	0	5,520,227
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	122,411	122,411	0	122,411
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	122,411	122,411	0	122,411
FACILITY OVERHEAD						
29.00	Facility Costs	0	294,884	294,884	-28,759	266,125
30.00	Administrative Costs	79,103	2,226,968	2,306,071	-75,205	2,230,866
31.00	Total Facility Overhead (sum of lines 29 and 30)	79,103	2,521,852	2,600,955	-103,964	2,496,991
32.00	Total facility costs (sum of lines 22, 28 and 31)	202,618	8,040,975	8,243,593	-103,964	8,139,629

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0145

Period:

Worksheet M-1

Component CCN: 14-8503

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 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	2,388,544	1.00
2.00	Physician Assistant	0	178,946	2.00
3.00	Nurse Practitioner	0	1,975,074	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	275,883	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	135,778	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,954,225	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	72,381	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	493,621	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	566,002	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	5,520,227	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	122,411	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	122,411	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	266,125	29.00
30.00	Administrative Costs	481,396	2,712,262	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	481,396	2,978,387	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	481,396	8,621,025	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0145

Period:

Worksheet M-2

Component CCN: 14-8503

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 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	7.10	20,976	4,200	29,820		1.00
2.00	Physician Assistant	1.40	4,836	2,100	2,940		2.00
3.00	Nurse Practitioner	8.41	13,554	2,100	17,661		3.00
4.00	Subtotal (sum of lines 1 through 3)	16.91	39,366		50,421	50,421	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)	16.91	39,366			50,421	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					5,520,227	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					122,411	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,642,638	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.978306	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					2,978,387	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,726,709	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,705,096	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,705,096	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,581,330	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					11,101,557	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0145 Component CCN: 14-8503	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 11/23/2021 10:59 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)			11,101,557	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			744,336	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			10,357,221	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			50,421	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)			50,421	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			205.41	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	247.89	8.00
9.00	Rate for Program covered visits (see instructions)	205.41	205.41	205.41	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	4,816	3,169	3,080	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	989,255	650,944	632,663	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	2,272,862		16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,110,682		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		44,583		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		48,010		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,596,991		16.04
16.05	Total program cost (see instructions)	0	1,645,001		16.05
17.00	Primary payer amounts		333		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		228,613		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		367,497		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,644,668		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		152,876		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,797,544		22.00
23.00	Allowable bad debts (see instructions)		33,822		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		21,984		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26,037		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,819,528		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,917,046		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)		-97,518		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 VACCINE COST

Provider CCN: 14-0145

Period:

Worksheet M-4

Component CCN: 14-8503

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/23/2021 10:59 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,954,225	4,954,225	4,954,225	4,954,225	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005951	0.014377	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	29,483	71,227	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	201,174	68,235	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	230,657	139,462	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,520,227	5,520,227	5,520,227	5,520,227	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,581,330	5,581,330	5,581,330	5,581,330	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.041784	0.025264	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	233,210	141,007	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	463,867	280,469	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,256	3,034	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	369.32	92.44	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	254	639	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	93,807	59,069	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		744,336			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		152,876			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0145 Component CCN: 14-8503	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/23/2021 10:59 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,826,434	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		03/17/2021	79,486		3.01
3.02		03/17/2021	11,126		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)		90,612		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,917,046		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		97,518		6.02
7.00	Total Medicare program liability (see instructions)		1,819,528		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00