

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/28/2021 3:27 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/28/2021	Time: 3:27 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 15101 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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) LYNN GOINES

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	1,099,540	1,592,003	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	315,291	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC (MMC) I	0		-75,340		0	10.00
10.01	RURAL HEALTH CLINIC (FCC) II	0		-97,963		0	10.01
10.02	RURAL HEALTH CLINIC (ICC) III	0		-2,959		0	10.02
200.00	Total	0	1,414,831	1,415,741	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: 14-1323		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/28/2021 3:27 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 28 CHICK STREET			PO Box:				1.00		
2.00	City: METROPOLIS			State: IL		Zip Code: 62960-		County: MASSAC 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		MASSAC FAMILY CARE CLINIC	148598	99916		05/17/2019	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		MASSAC INTEGRATED CARE CLINIC	148618	99916		10/23/2020	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)						04/01/2020	03/31/2021		
21.00	Type of Control (see instructions)						11			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1323		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/28/2021 3:27 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000		64.00

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Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/28/2021 3:27 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/28/2021 3:27 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	107,124	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1323		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/28/2021 3:27 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				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.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1323		Period: From 04/01/2020 To 03/31/2021 Worksheet S-2 Part II Date/Time Prepared: 8/28/2021 3:27 pm				
				Y/N	Date			
				1.00	2.00			
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.								
COMPLETED BY ALL HOSPITALS								
Provider Organization and Operation								
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N		1.00		
				Y/N	Date	V/I		
				1.00	2.00	3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N		2.00		
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N		3.00		
				Y/N	Type	Date		
				1.00	2.00	3.00		
Financial Data and Reports								
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	08/31/2021	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00	
				Y/N	Legal Oper.			
				1.00	2.00			
Approved Educational Activities								
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00		
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00		
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00		
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N		9.00		
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N		10.00		
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N		11.00		
				Y/N				
				1.00				
Bad Debts								
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y		12.00		
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N		13.00		
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N		14.00		
Bed Complement								
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N		15.00		
				Part A		Part B		
				Y/N	Date	Y/N	Date	
				1.00	2.00	3.00	4.00	
PS&R Data								
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	08/13/2021	Y	08/13/2021	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)			N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/28/2021 3:27 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	LEE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRIN		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: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	229,696.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	229,696.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	229,696.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC (MMC)	88.00				0	26.00
26.01 RURAL HEALTH CLINIC (FCC)	88.01				0	26.01
26.02 RURAL HEALTH CLINIC (ICC)	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,025	195	1,302			1.00
2.00	HMO and other (see instructions)	113	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	244	0	244			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		8	8			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,269	203	1,554			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,269	203	1,554	0.00	167.33	14.00
15.00	CAH visits	6,571	0	24,517			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (MMC)	1,658	0	6,352	0.00	12.50	26.00
26.01	RURAL HEALTH CLINIC (FCC)	701	0	4,181	0.00	8.70	26.01
26.02	RURAL HEALTH CLINIC (ICC)	151	0	847	0.00	2.20	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	190.73	27.00
28.00	Observation Bed Days		0	84			28.00
29.00	Ambulance Trips	23					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	237	51	312	1.00
2.00 HMO and other (see instructions)			22	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	237	51	312	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC (MMC)	0.00					26.00
26.01 RURAL HEALTH CLINIC (FCC)	0.00					26.01
26.02 RURAL HEALTH CLINIC (ICC)	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-3478		Period: From 04/01/2020 To 03/31/2021 Worksheet S-8 Date/Time Prepared: 8/28/2021 3:27 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	28 CHICK STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL 62960	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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	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.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASSAC		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1323

Period:

Worksheet S-8

Component CCN: 14-3478

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	16:30				11.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-8598		Period: From 04/01/2020 To 03/31/2021 Worksheet S-8 Date/Time Prepared: 8/28/2021 3:27 pm	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	28 CHICK STREET			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS IL 62960			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	from
		1.00	2.00	3.00	4.00
		1.00		2.00	
11.00	Facility hours of operations (1)				11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			0 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.				0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		1.00		2.00	
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
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASSAC			2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		6.00		7.00	
11.00	Facility hours of operations (1)				11.00
		1.00		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1323

Period:

Worksheet S-8

Component CCN: 14-8598

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

RHC II

Cost

		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
	CLINIC						11.00	

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-8618		Period: From 04/01/2020 To 03/31/2021 Worksheet S-8 Date/Time Prepared: 8/28/2021 3:27 pm	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	510 W. 10TH STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL 62960	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.)	Y		1	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:30	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASSAC		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:30	08:00	17:30	08:00
		17:30		08:00	17:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1323

Period:

Worksheet S-8

Component CCN: 14-8618

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet S-10 Date/Time Prepared: 8/28/2021 3:27 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.710313 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,868,528 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	13,324,646		6.00
7.00	Medicaid cost (line 1 times line 6)	9,464,669		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)	6,596,141		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)	6,596,141		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)	107,798	0	107,798 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	76,570	0	76,570 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)	76,570	0	76,570 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)	814,058		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	481,692		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	741,066		27.01
28.00	Non-Medicare bad debt expense (see instructions)	72,992		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	311,221		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	387,791		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,983,932		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		942,114	942,114	252,569	1,194,683
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP		923,479	923,479	149,660	1,073,139
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,683,598	3,683,598	0	3,683,598
5.00	00500	ADMINISTRATIVE & GENERAL	2,349,946	2,954,564	5,304,510	-50,491	5,254,019
7.00	00700	OPERATION OF PLANT	240,655	1,022,250	1,262,905	-634	1,262,271
8.00	00800	LAUNDRY & LINEN SERVICE	14,417	117,491	131,908	0	131,908
9.00	00900	HOUSEKEEPING	305,549	116,752	422,301	0	422,301
10.00	01000	DIETARY	307,780	173,062	480,842	-57,315	423,527
11.00	01100	CAFETERIA	0	0	0	56,812	56,812
13.00	01300	NURSING ADMINISTRATION	205,049	6,164	211,213	-4,585	206,628
16.00	01600	MEDICAL RECORDS & LIBRARY	201,731	38,772	240,503	-2,269	238,234
17.00	01700	SOCIAL SERVICE	180,950	16,475	197,425	0	197,425
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	970,228	75,640	1,045,868	241,952	1,287,820
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	196,792	264,291	461,083	-128,108	332,975
53.00	05300	ANESTHESIOLOGY	0	313,097	313,097	0	313,097
54.00	05400	RADIOLOGY-DIAGNOSTIC	599,422	526,222	1,125,644	-16,401	1,109,243
60.00	06000	LABORATORY	658,267	1,141,112	1,799,379	-2,539	1,796,840
65.00	06500	RESPIRATORY THERAPY	364,346	64,974	429,320	-27,508	401,812
66.00	06600	PHYSICAL THERAPY	486,954	22,571	509,525	0	509,525
69.00	06900	ELECTROCARDIOLOGY	44,512	158,049	202,561	11,270	213,831
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,626	14,578	66,204	48,006	114,210
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,494	10,494
73.00	07300	DRUGS CHARGED TO PATIENTS	401,698	511,316	913,014	49,096	962,110
76.00	03550	GERIATRIC PSYCH	226,424	120,560	346,984	0	346,984
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	770,714	425,357	1,196,071	-278,644	917,427
88.01	08801	RURAL HEALTH CLINIC (FCC)	627,913	50,331	678,244	-16,801	661,443
88.02	08802	RURAL HEALTH CLINIC (ICC)	379,792	83,825	463,617	-38,997	424,620
90.00	09000	CLINIC	0	0	0	36,729	36,729
90.01	04951	WOUND CARE	11,091	90,701	101,792	0	101,792
91.00	09100	EMERGENCY	806,607	1,598,315	2,404,922	-25,924	2,378,998
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	18,758	18,758
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	514,160	67,491	581,651	-5,095	576,556
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		220,035	220,035	-220,035	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,916,623	15,743,186	26,659,809	0	26,659,809
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	FOUNDATION	26,370	28,202	54,572	0	54,572
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	10,942,993	15,771,388	26,714,381	0	26,714,381

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-186,335	1,008,348	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	-1,168	-1,168	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,270	1,071,869	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-230	3,683,368	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-135,013	5,119,006	5.00
7.00	00700	OPERATION OF PLANT	0	1,262,271	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,908	8.00
9.00	00900	HOUSEKEEPING	0	422,301	9.00
10.00	01000	DIETARY	0	423,527	10.00
11.00	01100	CAFETERIA	0	56,812	11.00
13.00	01300	NURSING ADMINISTRATION	0	206,628	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-162	238,072	16.00
17.00	01700	SOCIAL SERVICE	0	197,425	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-230,702	1,057,118	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	332,975	50.00
53.00	05300	ANESTHESIOLOGY	0	313,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,109,243	54.00
60.00	06000	LABORATORY	-30,000	1,766,840	60.00
65.00	06500	RESPIRATORY THERAPY	0	401,812	65.00
66.00	06600	PHYSICAL THERAPY	0	509,525	66.00
69.00	06900	ELECTROCARDIOLOGY	-101,953	111,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-2,365	111,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,295	959,815	73.00
76.00	03550	GERIATRIC PSYCH	-657	346,327	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MMC)	-12,374	905,053	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	661,443	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	424,620	88.02
90.00	09000	CLINIC	0	36,729	90.00
90.01	04951	WOUND CARE	0	101,792	90.01
91.00	09100	EMERGENCY	0	2,378,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	18,758	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	18,758	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	576,556	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-704,524	25,955,285	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	FOUNDATION	0	54,572	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-704,524	26,009,857	200.00

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/28/2021 3:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	218,664	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,371	2.00	
	TOTALS		0	220,035		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	0	56,812	1.00	
	TOTALS		0	56,812		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	148,289	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	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
	TOTALS		0	148,289		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	50,545	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	
	TOTALS		0	50,545		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	49,096	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	
	TOTALS		0	49,096		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,494	1.00	
	TOTALS		0	10,494		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	11,270	0	1.00	
	TOTALS		11,270	0		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,905	1.00	
	TOTALS		0	33,905		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	264,256	0	1.00	
	TOTALS		264,256	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICE	93.00	18,758	0	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		18,758	0		
	N - ICC CLINIC SPLIT					
1.00	CLINIC	90.00	0	36,729	1.00	
	TOTALS		0	36,729		
500.00	Grand Total: Increases		294,284	605,905	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/28/2021 3:27 pm

	Decreases						8/28/2021 3:27 PM
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	220,035	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	220,035			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	56,812	0		1.00
	TOTALS		0	56,812			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,586	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,204	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,269	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,539	0		4.00
5.00	OPERATING ROOM	50.00	0	106,056	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,539	0		6.00
7.00	LABORATORY	60.00	0	2,539	0		7.00
8.00	RURAL HEALTH CLINIC (MMC)	88.00	0	2,540	0		8.00
9.00	RURAL HEALTH CLINIC (FCC)	88.01	0	2,480	0		9.00
10.00	RURAL HEALTH CLINIC (ICC)	88.02	0	286	0		10.00
11.00	EMERGENCY	91.00	0	2,539	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	2,539	0		12.00
13.00	OPERATION OF PLANT	7.00	0	634	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,539	0		14.00
	TOTALS		0	148,289			
	D - MED SUPPLIES RECLASS						
1.00	RURAL HEALTH CLINIC (FCC)	88.01	0	49	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,813	0		2.00
3.00	OPERATING ROOM	50.00	0	11,470	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	16,238	0		4.00
5.00	RURAL HEALTH CLINIC (MMC)	88.00	0	320	0		5.00
6.00	EMERGENCY	91.00	0	18,499	0		6.00
7.00	AMBULANCE SERVICES	95.00	0	156	0		7.00
	TOTALS		0	50,545			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	503	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,381	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,297	0		3.00
4.00	OPERATING ROOM	50.00	0	88	0		4.00
5.00	AMBULANCE SERVICES	95.00	0	2,400	0		5.00
6.00	RURAL HEALTH CLINIC (ICC)	88.02	0	1,982	0		6.00
7.00	RURAL HEALTH CLINIC (MMC)	88.00	0	11,528	0		7.00
8.00	RURAL HEALTH CLINIC (FCC)	88.01	0	14,272	0		8.00
9.00	EMERGENCY	91.00	0	783	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,862	0		10.00
	TOTALS		0	49,096			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	10,494	0		1.00
	TOTALS		0	10,494			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	11,270	0	0		1.00
	TOTALS		11,270	0			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,905	12		1.00
	TOTALS		0	33,905			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC (MMC)	88.00	264,256	0	0		1.00
	TOTALS		264,256	0			
	M - BLOOD TRANSFUSION						
1.00	ADULTS & PEDIATRICS	30.00	14,655	0	0		1.00
2.00	EMERGENCY	91.00	4,103	0	0		2.00
	TOTALS		18,758	0			
	N - ICC CLINIC SPLIT						
1.00	RURAL HEALTH CLINIC (ICC)	88.02	0	36,729	0		1.00
	TOTALS		0	36,729			
500.00	Grand Total: Decreases		294,284	605,905			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0	0	0	0	1.00	
2.00	Land Improvements	1,096,762	0	0	0	0	2.00	
3.00	Buildings and Fixtures	17,073,656	0	0	0	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	8,161,620	0	0	0	0	6.00	
7.00	HIT designated Assets	424,784	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	26,822,802	0	0	0	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	26,822,802	0	0	0	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0				1.00	
2.00	Land Improvements	1,096,762	0				2.00	
3.00	Buildings and Fixtures	17,073,656	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,161,620	0				6.00	
7.00	HIT designated Assets	424,784	0				7.00	
8.00	Subtotal (sum of lines 1-7)	26,822,802	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	26,822,802	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	942,114	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	923,479	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,865,593	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	942,114				1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	923,479				2.00
3.00	Total (sum of lines 1-2)	0	1,865,593				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	17,583,442	-53,822	17,637,264	0.700664	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,373,864	-161,073	7,534,937	0.299336	0	2.00
3.00	Total (sum of lines 1-2)	24,957,306	-214,895	25,172,201	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	942,114	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	922,209	148,289	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,864,323	148,289	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	32,329	33,905	0	0	1,008,348	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	-1,168	0	0	0	-1,168	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,371	0	0	0	1,071,869	2.00
3.00	Total (sum of lines 1-2)	32,532	33,905	0	0	2,079,049	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-186,335	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,168	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	11	1.01
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0		0.00	0	3.00
3.00	Investment income - other (chapter 2)		0		0.00	0	4.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	5.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	6.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,266	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-332,655			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-162	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00			3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-7,848	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	LAB REBATES	B	-30,000	LABORATORY	60.00	0	34.00
35.00	PHARMACY REBATES	B	-2,295	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
37.00	OTHER REVENUE	B	-71,052	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-2,365	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
42.00	LOBBYING EXPENSE	A	-10,524	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	RHC MISC INCOME	B	-12,374	RURAL HEALTH CLINIC (MMC)	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-657	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,270	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-882	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-230	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.05	MARKETING EXPENSE	A	-43,441	ADMINISTRATIVE & GENERAL	5.00	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-704,524				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/28/2021 3:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	264,256	230,702	33,554	0	0	1.00
2.00	91.00	EMERGENCY	1,506,279	0	1,506,279	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	101,953	101,953	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,872,488	332,655	1,539,833	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	230,702		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	101,953		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	332,655		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
		0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,008,348	1,008,348			1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	-1,168	0	-1,168		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,071,869			1,071,869	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,683,368	4,599	0	4,515	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,119,006	230,185	0	225,962	5.00
7.00	00700	OPERATION OF PLANT	1,262,271	88,354	0	86,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,908	18,396	0	18,058	8.00
9.00	00900	HOUSEKEEPING	422,301	6,774	0	6,650	9.00
10.00	01000	DIETARY	423,527	22,145	0	21,739	10.00
11.00	01100	CAFETERIA	56,812	9,266	0	9,096	11.00
13.00	01300	NURSING ADMINISTRATION	206,628	3,851	0	3,781	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,072	17,433	0	19,248	16.00
17.00	01700	SOCIAL SERVICE	197,425	2,050	0	2,013	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,057,118	166,650	0	163,593	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	332,975	102,276	0	100,399	50.00
53.00	05300	ANESTHESIOLOGY	313,097	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,243	55,471	0	54,453	54.00
60.00	06000	LABORATORY	1,766,840	13,491	0	13,244	60.00
65.00	06500	RESPIRATORY THERAPY	401,812	18,656	0	18,314	65.00
66.00	06600	PHYSICAL THERAPY	509,525	39,272	0	38,552	66.00
69.00	06900	ELECTROCARDIOLOGY	111,878	34,571	0	34,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,845	15,655	0	15,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,494	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	959,815	6,457	0	6,338	73.00
76.00	03550	GERIATRIC PSYCH	346,327	16,346	0	16,046	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	905,053	21,092	0	65,183	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	661,443	16,991	0	16,679	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	424,620	7,952	0	7,806	88.02
90.00	09000	CLINIC	36,729	6,207	0	6,094	90.00
90.01	04951	WOUND CARE	101,792	15,858	0	15,568	90.01
91.00	09100	EMERGENCY	2,378,998	66,447	0	65,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	18,758	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	576,556	0	0	35,071	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,955,285	1,006,445	0	1,070,001	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,903	0	1,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FOUNDATION	54,572	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers			-1,168	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,009,857	1,008,348	-1,168	1,071,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,692,482					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	792,941	6,368,094	6,368,094			5.00
7.00	00700	OPERATION OF PLANT	81,204	1,518,562	492,307	2,010,869		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,865	173,227	56,159	53,986	283,372	8.00
9.00	00900	HOUSEKEEPING	103,101	538,826	174,684	19,879		9.00
10.00	01000	DIETARY	103,854	571,265	185,200	64,989		10.00
11.00	01100	CAFETERIA	0	75,174	24,371	27,192		11.00
13.00	01300	NURSING ADMINISTRATION	69,189	283,449	91,892	11,302		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,070	342,823	111,141	51,160		16.00
17.00	01700	SOCIAL SERVICE	61,058	262,546	85,116	6,017		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	411,606	1,798,967	583,213	489,064	85,721	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	66,403	602,053	195,181	300,146	2,480	50.00
53.00	05300	ANESTHESIOLOGY	0	313,097	101,504	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,262	1,421,429	460,817	162,788	31,702	54.00
60.00	06000	LABORATORY	222,118	2,015,693	653,474	39,592	0	60.00
65.00	06500	RESPIRATORY THERAPY	119,138	557,920	180,874	54,750	0	65.00
66.00	06600	PHYSICAL THERAPY	164,312	751,661	243,683	115,252	27,958	66.00
69.00	06900	ELECTROCARDIOLOGY	18,822	199,542	64,690	101,456	4,814	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,420	160,287	51,964	45,941	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,494	3,402	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,545	1,108,155	359,256	18,948	0	73.00
76.00	03550	GERIATRIC PSYCH	76,402	455,121	147,547	47,969	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	170,894	1,162,222	376,784	61,897	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	211,876	906,989	294,039	49,864	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	128,153	568,531	184,314	23,336	0	88.02
90.00	09000	CLINIC	0	49,030	15,895	18,217	0	90.00
90.01	04951	WOUND CARE	3,742	136,960	44,401	46,539	729	90.01
91.00	09100	EMERGENCY	270,788	2,781,461	901,723	195,000	127,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	6,329	25,087	8,133	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	173,492	785,119	254,530	0	583	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,683,584	25,943,784	6,346,294	2,005,284	281,038	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,771	1,223	5,585	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,334	192.00
192.01	19201	FOUNDATION	8,898	63,470	20,577	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	-1,168	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,692,482	26,009,857	6,368,094	2,010,869	283,372	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	733,389				9.00
10.00	01000	DIETARY	30,509	851,963			10.00
11.00	01100	CAFETERIA	0	503,550	630,287		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	16,351	402,994	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,193	0	33,004	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	16,896	20,449	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	246,379	252,140	111,305	189,827	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,170	0	15,987	27,369	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,520	0	55,289	0	54.00
60.00	06000	LABORATORY	30,197	0	88,112	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,941	0	38,818	0	65.00
66.00	06600	PHYSICAL THERAPY	12,875	0	42,633	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,170	0	5,814	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,084	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,384	0	20,953	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	23,496	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	55,147	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	40,965	0	53,049	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	14,275	0	0	0	88.02
90.00	09000	CLINIC	11,135	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	150,284	0	96,953	165,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	678,144	755,690	627,744	402,994	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,245	96,273	2,543	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	733,389	851,963	630,287	402,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

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
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	391,024					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	391,024	0	4,505,546	0	4,505,546	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0	1,154,326	0	1,154,326	50.00
53.00	05300	ANESTHESIOLOGY		0	414,601	0	414,601	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	2,279,238	0	2,279,238	54.00
60.00	06000	LABORATORY		0	2,827,068	0	2,827,068	60.00
65.00	06500	RESPIRATORY THERAPY		0	855,303	0	855,303	65.00
66.00	06600	PHYSICAL THERAPY		0	1,218,875	0	1,218,875	66.00
69.00	06900	ELECTROCARDIOLOGY		0	377,486	0	377,486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	267,276	0	267,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	13,896	0	13,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	1,512,696	0	1,512,696	73.00
76.00	03550	GERIATRIC PSYCH		0	674,133	0	674,133	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)		0	1,656,050	0	1,656,050	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)		0	1,344,906	0	1,344,906	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)		0	790,456	0	790,456	88.02
90.00	09000	CLINIC		0	94,277	0	94,277	90.00
90.01	04951	WOUND CARE		0	228,629	0	228,629	90.01
91.00	09100	EMERGENCY		0	4,471,790	0	4,471,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE		0	33,220	0	33,220	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES		0	1,040,232	0	1,040,232	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	391,024	0	25,760,004	0	25,760,004	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	10,579	0	10,579	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	156,395	0	156,395	192.00
192.01	19201	FOUNDATION		0	84,047	0	84,047	192.01
193.00	19300	NONPAID WORKERS		0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers		0	-1,168	0	-1,168	201.00
202.00		TOTAL (sum lines 118 through 201)	391,024	0	26,009,857	0	26,009,857	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,599	0	0	4,515	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	230,185	0	0	225,962	5.00
7.00	00700	OPERATION OF PLANT	0	88,354	0	0	86,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,396	0	0	18,058	8.00
9.00	00900	HOUSEKEEPING	0	6,774	0	0	6,650	9.00
10.00	01000	DIETARY	0	22,145	0	0	21,739	10.00
11.00	01100	CAFETERIA	0	9,266	0	0	9,096	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,851	0	0	3,781	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,433	0	0	19,248	16.00
17.00	01700	SOCIAL SERVICE	0	2,050	0	0	2,013	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	166,650	0	0	163,593	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	102,276	0	0	100,399	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,471	0	0	54,453	54.00
60.00	06000	LABORATORY	0	13,491	0	0	13,244	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,656	0	0	18,314	65.00
66.00	06600	PHYSICAL THERAPY	0	39,272	0	0	38,552	66.00
69.00	06900	ELECTROCARDIOLOGY	0	34,571	0	0	34,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,655	0	0	15,367	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	6,457	0	0	6,338	73.00
76.00	03550	GERIATRIC PSYCH	0	16,346	0	0	16,046	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	21,092	0	0	65,183	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	16,991	0	0	16,679	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	7,952	0	0	7,806	88.02
90.00	09000	CLINIC	0	6,207	0	0	6,094	90.00
90.01	04951	WOUND CARE	0	15,858	0	0	15,568	90.01
91.00	09100	EMERGENCY	0	66,447	0	0	65,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	35,071	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,006,445	0	0	1,070,001	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,903	0	0	1,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	-1,168	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,008,348	-1,168	0	1,071,869	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,114	9,114				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	456,147	1,957	458,104			5.00
7.00	00700	OPERATION OF PLANT	175,087	200	35,416	210,703		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,454	12	4,040	5,657	46,163	8.00
9.00	00900	HOUSEKEEPING	13,424	255	12,566	2,083	0	9.00
10.00	01000	DIETARY	43,884	256	13,323	6,810	0	10.00
11.00	01100	CAFETERIA	18,362	0	1,753	2,849	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,632	171	6,611	1,184	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,681	168	7,995	5,361	0	16.00
17.00	01700	SOCIAL SERVICE	4,063	151	6,123	630	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	330,243	1,016	41,956	51,245	13,965	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	202,675	164	14,041	31,450	404	50.00
53.00	05300	ANESTHESIOLOGY	0	0	7,302	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,924	499	33,151	17,057	5,164	54.00
60.00	06000	LABORATORY	26,735	548	47,010	4,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	36,970	294	13,012	5,737	0	65.00
66.00	06600	PHYSICAL THERAPY	77,824	406	17,530	12,076	4,555	66.00
69.00	06900	ELECTROCARDIOLOGY	68,842	46	4,654	10,631	784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,022	43	3,738	4,814	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	245	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,795	335	25,844	1,985	0	73.00
76.00	03550	GERIATRIC PSYCH	32,392	189	10,614	5,026	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	86,275	422	27,105	6,486	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	33,670	523	21,153	5,225	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	15,758	316	13,259	2,445	0	88.02
90.00	09000	CLINIC	12,301	0	1,143	1,909	0	90.00
90.01	04951	WOUND CARE	31,426	9	3,194	4,876	119	90.01
91.00	09100	EMERGENCY	131,675	668	64,862	20,433	20,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	16	585	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	35,071	428	18,311	0	95	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,076,446	9,092	456,536	210,118	45,783	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,771	0	88	585	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	380	192.00
192.01	19201	FOUNDATION	0	22	1,480	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	-1,168	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,079,049	9,114	458,104	210,703	46,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	28,328					9.00
10.00	01000	DIETARY	1,178	65,451				10.00
11.00	01100	CAFETERIA	0	38,685	61,649			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,599	17,197		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	316	0	3,228	0	53,749	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,653	873	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	9,519	19,370	10,887	8,100	35,212	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45	0	1,564	1,168	978	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,836	0	5,408	0	9,808	54.00
60.00	06000	LABORATORY	1,166	0	8,618	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	886	0	3,797	0	0	65.00
66.00	06600	PHYSICAL THERAPY	497	0	4,170	0	2,441	66.00
69.00	06900	ELECTROCARDIOLOGY	45	0	569	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	888	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	208	0	2,049	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	2,298	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	2,130	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,582	0	5,189	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	551	0	0	0	0	88.02
90.00	09000	CLINIC	430	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,805	0	9,483	7,056	5,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,194	58,055	61,400	17,197	53,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,134	7,396	249	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,328	65,451	61,649	17,197	53,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

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
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	13,493					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,493		535,006	0	535,006	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		252,489	0	252,489	50.00
53.00	05300	ANESTHESIOLOGY	0		7,302	0	7,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		182,847	0	182,847	54.00
60.00	06000	LABORATORY	0		88,226	0	88,226	60.00
65.00	06500	RESPIRATORY THERAPY	0		60,696	0	60,696	65.00
66.00	06600	PHYSICAL THERAPY	0		119,499	0	119,499	66.00
69.00	06900	ELECTROCARDIOLOGY	0		85,571	0	85,571	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		40,505	0	40,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		245	0	245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		43,216	0	43,216	73.00
76.00	03550	GERIATRIC PSYCH	0		50,519	0	50,519	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	0		122,418	0	122,418	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0		67,342	0	67,342	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0		32,329	0	32,329	88.02
90.00	09000	CLINIC	0		15,783	0	15,783	90.00
90.01	04951	WOUND CARE	0		39,624	0	39,624	90.01
91.00	09100	EMERGENCY	0		265,989	0	265,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0		601	0	601	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		53,905	0	53,905	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,493	0	2,064,112	0	2,064,112	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,444	0	4,444	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		10,159	0	10,159	192.00
192.01	19201	FOUNDATION	0		1,502	0	1,502	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-1,168	0	-1,168	201.00
202.00		TOTAL (sum lines 118 through 201)	13,493	0	2,079,049	0	2,079,049	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
			1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,018					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				96,394		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	10,942,993	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,321	0	0	20,321	2,349,946	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	240,655	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	14,417	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	305,549	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	307,780	10.00
11.00	01100	CAFETERIA	818	0	0	818	0	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	205,049	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	201,731	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	180,950	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,219,829	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	196,792	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	599,422	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	658,267	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	353,076	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	486,954	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	55,782	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	51,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	401,698	73.00
76.00	03550	GERIATRIC PSYCH	1,443	0	0	1,443	226,424	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	1,862	0	0	5,862	506,458	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,500	0	0	1,500	627,913	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	702	0	0	702	379,792	88.02
90.00	09000	CLINIC	548	0	0	548	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	1,400	11,091	90.01
91.00	09100	EMERGENCY	5,866	0	0	5,866	802,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	18,758	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	514,160	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,850	0	0	96,226	10,916,623	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	26,370	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,008,348	-1,168	0	1,071,869	3,692,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.327462	0.000000	0.000000	11.119665	0.337429	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,114	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000833	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: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,368,094	19,642,931			5.00
7.00	00700	OPERATION OF PLANT	0	1,518,562	60,491		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	173,227	1,624	5,828	8.00
9.00	00900	HOUSEKEEPING	0	538,826	598	0	187,978 9.00
10.00	01000	DIETARY	0	571,265	1,955	0	7,820 10.00
11.00	01100	CAFETERIA	0	75,174	818	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	283,449	340	0	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	342,823	1,539	0	2,100 16.00
17.00	01700	SOCIAL SERVICE	0	262,546	181	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	0	1,798,967	14,712	1,763	63,150 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	602,053	9,029	51	300 50.00
53.00	05300	ANESTHESIOLOGY	0	313,097	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,421,429	4,897	652	12,180 54.00
60.00	06000	LABORATORY	0	2,015,693	1,191	0	7,740 60.00
65.00	06500	RESPIRATORY THERAPY	0	557,920	1,647	0	5,880 65.00
66.00	06600	PHYSICAL THERAPY	0	751,661	3,467	575	3,300 66.00
69.00	06900	ELECTROCARDIOLOGY	0	199,542	3,052	99	300 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	160,287	1,382	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,494	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,108,155	570	0	1,380 73.00
76.00	03550	GERIATRIC PSYCH	0	455,121	1,443	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	1,162,222	1,862	0	14,135 88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	906,989	1,500	0	10,500 88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	568,531	702	0	3,659 88.02
90.00	09000	CLINIC	0	49,030	548	0	2,854 90.00
90.01	04951	WOUND CARE	0	136,960	1,400	15	0 90.01
91.00	09100	EMERGENCY	0	2,781,461	5,866	2,613	38,520 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	25,087	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	785,119	0	12	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,368,094	19,575,690	60,323	5,780	173,818 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,771	168	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	48	14,160 192.00
192.01	19201	FOUNDATION	0	63,470	0	0	0 192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		6,368,094	2,010,869	283,372	733,389 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.324193	33.242449	48.622512	3.901462 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		458,104	210,703	46,163	28,328 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.023322	3.483212	7.920899	0.150698 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: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNED TI MES)	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	30,336				10.00
11.00	01100	CAFETERIA	17,930	10,408			11.00
13.00	01300	NURSING ADMINISTRATION	0	270	3,902		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	545	0	185,500	16.00
17.00	01700	SOCIAL SERVICE	0	279	198	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,978	1,838	1,838	121,525	100
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	264	265	3,375	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	913	0	33,850	0
60.00	06000	LABORATORY	0	1,455	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	641	0	0	0
66.00	06600	PHYSICAL THERAPY	0	704	0	8,425	0
69.00	06900	ELECTROCARDIOLOGY	0	96	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	150	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	346	0	0	0
76.00	03550	GERIATRIC PSYCH	0	388	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	876	0	0	0
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	04951	WOUND CARE	0	0	0	0	0
91.00	09100	EMERGENCY	0	1,601	1,601	18,325	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,908	10,366	3,902	185,500	100
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,428	42	0	0	0
192.01	19201	FOUNDATION	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
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)	851,963	630,287	402,994	546,321	391,024
203.00		Unit cost multiplier (Wkst. B, Part I)	28.084223	60.557936	103.278831	2.945127	3,910.240000
204.00		Cost to be allocated (per Wkst. B, Part II)	65,451	61,649	17,197	53,749	13,493
205.00		Unit cost multiplier (Wkst. B, Part II)	2.157536	5.923232	4.407227	0.289752	134.930000
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: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
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
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	GERIATRIC PSYCH	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (MMC)	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	88.02
90.00	09000	CLINIC	90.00
90.01	04951	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FOUNDATION	192.01
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	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

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-2

Date/Time Prepared:
8/28/2021 3:27 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,505,546		4,505,546	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,154,326		1,154,326	0	0	50.00
53.00	05300	ANESTHESIOLOGY	414,601		414,601	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,279,238		2,279,238	0	0	54.00
60.00	06000	LABORATORY	2,827,068		2,827,068	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	855,303	0	855,303	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,218,875	0	1,218,875	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	377,486		377,486	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	267,276		267,276	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,896		13,896	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,512,696		1,512,696	0	0	73.00
76.00	03550	GERIATRIC PSYCH	674,133		674,133	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	1,656,050		1,656,050	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,344,906		1,344,906	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	790,456		790,456	0	0	88.02
90.00	09000	CLINIC	94,277		94,277	0	0	90.00
90.01	04951	WOUND CARE	228,629		228,629	0	0	90.01
91.00	09100	EMERGENCY	4,471,790		4,471,790	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	232,133		232,133	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	33,220		33,220	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,040,232		1,040,232	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,992,137	0	25,992,137	0	0	200.00
201.00		Less Observation Beds	232,133		232,133			201.00
202.00		Total (see instructions)	25,760,004	0	25,760,004	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,458,324		1,458,324			30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,241,554	1,241,554	0.929743	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	289,002	289,002	1.434596	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,323	12,182,813	12,669,136	0.179905	0.000000	54.00	
60.00	06000	LABORATORY	607,364	6,195,676	6,803,040	0.415560	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	128,467	161,503	289,970	2.949626	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	161,384	1,024,448	1,185,832	1.027865	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	315,828	1,492,349	1,808,177	0.208766	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,844	54,715	60,559	4.413481	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,741	15,741	0.882790	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	838,654	1,293,600	2,132,254	0.709435	0.000000	73.00	
76.00	03550	GERIATRIC PSYCH	0	413,244	413,244	1.631320	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	680,689	680,689			88.00	
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	559,392	559,392			88.01	
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	54,047	54,047			88.02	
90.00	09000	CLINIC	0	42,150	42,150	2.236702	0.000000	90.00	
90.01	04951	WOUND CARE	0	317,006	317,006	0.721213	0.000000	90.01	
91.00	09100	EMERGENCY	16,005	4,022,075	4,038,080	1.107405	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	87,696	87,696	2.647019	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE	0	24,320	24,320	1.365954	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,095,491	2,095,491	0.496414	0.000000	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	4,018,193	32,247,511	36,265,704			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	4,018,193	32,247,511	36,265,704			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 GERIATRIC PSYCH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MMC)				88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)				88.01
88.02	08802 RURAL HEALTH CLINIC (ICC)				88.02
90.00	09000 CLINIC	0.000000			90.00
90.01	04951 WOUND CARE	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	252,489	1,241,554	0.203365	0	0	50.00
53.00	05300 ANESTHESIOLOGY	7,302	289,002	0.025266	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	182,847	12,669,136	0.014432	355,073	5,124	54.00
60.00	06000 LABORATORY	88,226	6,803,040	0.012969	496,196	6,435	60.00
65.00	06500 RESPIRATORY THERAPY	60,696	289,970	0.209318	29,758	6,229	65.00
66.00	06600 PHYSICAL THERAPY	119,499	1,185,832	0.100772	58,354	5,880	66.00
69.00	06900 ELECTROCARDIOLOGY	85,571	1,808,177	0.047324	209,709	9,924	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40,505	60,559	0.668852	3,174	2,123	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	245	15,741	0.015564	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	43,216	2,132,254	0.020268	594,688	12,053	73.00
76.00	03550 GERIATRIC PSYCH	50,519	413,244	0.122250	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (MMC)	122,418	680,689	0.179844	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	67,342	559,392	0.120384	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC (ICC)	32,329	54,047	0.598165	0	0	88.02
90.00	09000 CLINIC	15,783	42,150	0.374448	0	0	90.00
90.01	04951 WOUND CARE	39,624	317,006	0.124994	0	0	90.01
91.00	09100 EMERGENCY	265,989	4,038,080	0.065870	9,227	608	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	27,564	87,696	0.314313	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	601	24,320	0.024712	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,502,765	32,711,889		1,756,179	48,376	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1323		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/28/2021 3:27 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,241,554	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	289,002	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,669,136	0.000000
60.00	06000	LABORATORY	0	0	0	6,803,040	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	289,970	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,185,832	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,808,177	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	60,559	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,741	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,132,254	0.000000
76.00	03550	GERIATRIC PSYCH	0	0	0	413,244	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	680,689	0.000000
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	559,392	0.000000
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	54,047	0.000000
90.00	09000	CLINIC	0	0	0	42,150	0.000000
90.01	04951	WOUND CARE	0	0	0	317,006	0.000000
91.00	09100	EMERGENCY	0	0	0	4,038,080	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	87,696	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	24,320	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	32,711,889	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	355,073	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	496,196	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	29,758	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	58,354	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	209,709	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,174	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	594,688	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MMC)	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	9,227	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,756,179	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/28/2021 3:27 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.929743	0	563,455	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.434596	0	153,174	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179905	0	4,417,665	0	0	54.00
60.00	06000	LABORATORY	0.415560	0	2,014,037	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2.949626	0	9,193	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.027865	0	468,966	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.208766	0	582,934	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.413481	0	34,874	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.882790	0	8,260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709435	0	787,457	0	0	73.00
76.00	03550	GERIATRIC PSYCH	1.631320	0	353,001	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)						88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)						88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)						88.02
90.00	09000	CLINIC	2.236702	0	39,750	0	0	90.00
90.01	04951	WOUND CARE	0.721213	0	307,728	0	0	90.01
91.00	09100	EMERGENCY	1.107405	0	1,140,746	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.647019	0	22,519	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.365954	0	17,213	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.496414		0			95.00
200.00		Subtotal (see instructions)		0	10,920,972	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	10,920,972	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/28/2021 3:27 pm

				Title XVIII	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	523,868	0		50.00
53.00	05300	ANESTHESIOLOGY	219,743	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	794,760	0		54.00
60.00	06000	LABORATORY	836,953	0		60.00
65.00	06500	RESPIRATORY THERAPY	27,116	0		65.00
66.00	06600	PHYSICAL THERAPY	482,034	0		66.00
69.00	06900	ELECTROCARDIOLOGY	121,697	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,916	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,292	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,650	0		73.00
76.00	03550	GERIATRIC PSYCH	575,858	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MMC)				88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)				88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)				88.02
90.00	09000	CLINIC	88,909	0		90.00
90.01	04951	WOUND CARE	221,937	0		90.01
91.00	09100	EMERGENCY	1,263,268	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	59,608	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	23,512	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,959,121	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,959,121	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2020
To 03/31/2021

Part IV
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

From 04/01/2020

To 03/31/2021

Worksheet D

Part IV

Date/Time Prepared:

8/28/2021 3:27 pm

Cost Center Description			Title XVIII		Swing Beds - SNF	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,241,554	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	289,002	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,669,136	0.000000
60.00	06000	LABORATORY	0	0	0	6,803,040	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	289,970	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,185,832	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,808,177	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	60,559	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,741	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,132,254	0.000000
76.00	03550	GERIATRIC PSYCH	0	0	0	413,244	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	680,689	0.000000
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	559,392	0.000000
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	54,047	0.000000
90.00	09000	CLINIC	0	0	0	42,150	0.000000
90.01	04951	WOUND CARE	0	0	0	317,006	0.000000
91.00	09100	EMERGENCY	0	0	0	4,038,080	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	87,696	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	24,320	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	32,711,889	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

From 04/01/2020

To 03/31/2021

Worksheet D

Part IV

Date/Time Prepared:

8/28/2021 3:27 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	5,847	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	50,788	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	29,355	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	87,796	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	11,800	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	144	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	76,736	0	0	0	73.00
76.00	03550 GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (MMC)	0.000000	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC (ICC)	0.000000	0	0	0	0	88.02
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04951 WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.000000	152	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		262,618	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2020
To 03/31/2021Part V
Date/Time Prepared:
8/28/2021 3:27 pm

			Title XVIII	Swing Beds - SNF		Cost		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.929743	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.434596	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179905	0	0	0	0	54.00
60.00	06000	LABORATORY	0.415560	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2.949626	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.027865	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.208766	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.413481	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.882790	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.709435	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	1.631320	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MMC)						88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)						88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)						88.02
90.00	09000	CLINIC	2.236702	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.721213	0	0	0	0	90.01
91.00	09100	EMERGENCY	1.107405	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.647019	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.365954	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.496414		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2020
To 03/31/2021Part V
Date/Time Prepared:
8/28/2021 3:27 pm

				Title XVIII	Swing Beds - SNF	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	GERIATRIC PSYCH	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MMC)				88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)				88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)				88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,638	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,386	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,302	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			243	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			1	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			8	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,025	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)			243	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)			1	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,505,546	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)			1,061	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			675,353	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,830,193	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)			3,830,193	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)			2,763.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,832,577	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)			2,832,577	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					907,731	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,740,308	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					671,528	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					2,763	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					674,291	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					84	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,763.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					232,133	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/28/2021 3:27 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	535,006	4,505,546	0.118744	232,133	27,564
91.00	Nursing School cost	0	4,505,546	0.000000	232,133	0
92.00	Allied health cost	0	4,505,546	0.000000	232,133	0
93.00	All other Medical Education	0	4,505,546	0.000000	232,133	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/28/2021 3:27 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		774,204		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.929743	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.434596	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179905	355,073	63,879	54.00
60.00	06000 LABORATORY	0.415560	496,196	206,199	60.00
65.00	06500 RESPIRATORY THERAPY	2.949626	29,758	87,775	65.00
66.00	06600 PHYSICAL THERAPY	1.027865	58,354	59,980	66.00
69.00	06900 ELECTROCARDIOLOGY	0.208766	209,709	43,780	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4.413481	3,174	14,008	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.882790	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.709435	594,688	421,892	73.00
76.00	03550 GERIATRIC PSYCH	1.631320	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MMC)	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC (ICC)	0.000000		0	88.02
90.00	09000 CLINIC	2.236702	0	0	90.00
90.01	04951 WOUND CARE	0.721213	0	0	90.01
91.00	09100 EMERGENCY	1.107405	9,227	10,218	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.647019	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	1.365954	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,756,179	907,731	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,756,179		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323 Component CCN: 14-Z323	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.929743	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.434596	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179905	5,847	1,052	54.00
60.00	06000 LABORATORY	0.415560	50,788	21,105	60.00
65.00	06500 RESPIRATORY THERAPY	2.949626	29,355	86,586	65.00
66.00	06600 PHYSICAL THERAPY	1.027865	87,796	90,242	66.00
69.00	06900 ELECTROCARDIOLOGY	0.208766	11,800	2,463	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4.413481	144	636	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.882790	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.709435	76,736	54,439	73.00
76.00	03550 GERIATRIC PSYCH	1.631320	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MMC)	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC (ICC)	0.000000		0	88.02
90.00	09000 CLINIC	2.236702	0	0	90.00
90.01	04951 WOUND CARE	0.721213	0	0	90.01
91.00	09100 EMERGENCY	1.107405	152	168	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.647019	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	1.365954	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		262,618	256,691	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		262,618		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/28/2021 3:27 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,959,121	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,959,121	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,018,712	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		34,898	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,715,921	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)		4,267,893	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)		4,267,893	30.00
31.00	Primary payer payments		239	31.00
32.00	Subtotal (line 30 minus line 31)		4,267,654	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)		588,431	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		382,480	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		533,833	36.00
37.00	Subtotal (see instructions)		4,650,134	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)		4,650,134	40.00
40.01	Sequestration adjustment (see instructions)		7,440	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		3,050,691	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)		1,592,003	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: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/28/2021 3:27 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,295,351		2,892,784	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	11/09/2020	143,956	11/09/2020	94,589	3.01
3.02		03/22/2021	49,629	03/22/2021	63,318	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)		193,585		157,907	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,488,936		3,050,691	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		1,099,540		1,592,003	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,588,476		4,642,694	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323

Period:

Worksheet E-1

Component CCN: 14-Z323

From 04/01/2020
To 03/31/2021Part I
Date/Time Prepared:
8/28/2021 3:27 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		549,625		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	11/09/2020	68,461		0	3.01
3.02		03/22/2021	5,411		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)		73,872		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)		623,497		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		315,291		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		938,788		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet E-1 Part II Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1323 Component CCN: 14-Z323	Period: From 04/01/2020 To 03/31/2021	Worksheet E-2 Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		681,034	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)		259,258	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		244	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)		940,292	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		940,292	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)		940,292	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		940,292	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)		940,292	0	19.00
19.01	Sequestration adjustment (see instructions)		1,504	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		623,497	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)		315,291	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
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part V Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			3,740,308	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			3,740,308	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,777,711	6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,777,711	19.00
20.00	Deductibles (exclude professional component)			262,112	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			3,515,599	22.00
23.00	Coinsurance			2,578	23.00
24.00	Subtotal (line 22 minus line 23)			3,513,021	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			124,933	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			81,206	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			78,135	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,594,227	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			3,594,227	30.00
30.01	Sequestration adjustment (see instructions)			5,751	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM			0	30.03
31.00	Interim payments			2,488,936	31.00
31.01	Interim payments-PARHM			0	31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			1,099,540	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	34.00

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

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/28/2021 3:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	24,937,635	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	4,100,761	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,968,598	0	0	0	6.00
7.00	Inventory	324,282	0	0	0	7.00
8.00	Prepaid expenses	1,187,319	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,581,399	0	0	0	11.00
FIXED ASSETS						
12.00	Land	227,659	0	0	0	12.00
13.00	Land improvements	1,099,097	0	0	0	13.00
14.00	Accumulated depreciation	-939,771	0	0	0	14.00
15.00	Buildings	21,366,197	0	0	0	15.00
16.00	Accumulated depreciation	-10,738,101	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,976,372	0	0	0	23.00
24.00	Accumulated depreciation	-8,136,154	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	43,804	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,899,103	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	141,653	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	141,653	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,622,155	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	554,941	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,823,671	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,105,911	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,484,523	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,940,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,016,869	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,956,869	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,441,392	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,180,763				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	26,180,763	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,622,155	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/28/2021 3:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,649,279		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,142,203				2.00
3.00	Total (sum of line 1 and line 2)		28,791,482		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)		28,791,482		0		11.00
12.00	NON OPER EQUITY	2,610,719		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)		2,610,719		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,180,763		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	NON OPER EQUITY		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: 14-1323

Period:
From 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2021 3:27 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,662,927		1,662,927	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	99,001		99,001	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)	1,761,928		1,761,928	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,761,928		1,761,928	17.00
18.00	Ancillary services	2,559,869	32,365,716	34,925,585	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (MMC)	0	559,392	559,392	20.00
20.01	RURAL HEALTH CLINIC (FCC)	0	559,392	559,392	20.01
20.02	RURAL HEALTH CLINIC (ICC)	0	96,197	96,197	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,095,491	2,095,491	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,321,797	35,676,188	39,997,985	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,714,381		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)		26,714,381		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/28/2021 3:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	39,997,985	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,350,459	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,647,526	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,714,381	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,066,855	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,209,058	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,209,058	25.00
26.00	Total (line 5 plus line 25)	4,142,203	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)	4,142,203	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

						RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	352,982	0	352,982	0	352,982	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	182,972	0	182,972	0	182,972	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	0	0	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00		
10.00	Subtotal (sum of lines 1 through 9)	535,954	0	535,954	0	535,954	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	95,205	95,205	0	95,205	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	95,205	95,205	0	95,205	14.00		
15.00	Medical Supplies	0	14,989	14,989	0	14,989	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	25,372	25,372	0	25,372	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	40,361	40,361	0	40,361	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	535,954	135,566	671,520	0	671,520	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	20,826	20,826	0	20,826	29.00		
30.00	Administrative Costs	212,707	0	212,707	0	212,707	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	212,707	20,826	233,533	0	233,533	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	748,661	156,392	905,053	0	905,053	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	352,982	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	182,972	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	535,954	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	95,205	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	95,205	14.00
15.00	Medical Supplies	0	14,989	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	25,372	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,361	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	671,520	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	20,826	29.00
30.00	Administrative Costs	0	212,707	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	233,533	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	905,053	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8598

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

				RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	255,369	0	255,369	0	255,369	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	98,129	0	98,129	0	98,129	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	353,498	0	353,498	0	353,498	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	8,988	8,988	0	8,988	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	8,142	8,142	0	8,142	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,130	17,130	0	17,130	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	353,498	17,130	370,628	0	370,628	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	4,189	4,189	0	4,189	29.00
30.00	Administrative Costs	274,414	12,212	286,626	0	286,626	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	274,414	16,401	290,815	0	290,815	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	627,912	33,531	661,443	0	661,443	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8598

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

				RHC II	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	255,369	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	98,129	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	0	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	353,498	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	8,988	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	8,142	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	17,130	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	370,628	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	4,189	29.00	
30.00	Administrative Costs	0	286,626	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	290,815	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	661,443	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8618

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	348,921	0	348,921	0	348,921
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	0	0	0	0	0
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	0	0	0	0	0
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	348,921	0	348,921	0	348,921
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	17,377	17,377	0	17,377
14.00 Subtotal (sum of lines 11 through 13)	0	17,377	17,377	0	17,377
15.00 Medical Supplies	0	2,619	2,619	0	2,619
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	1,926	1,926	0	1,926
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	4,545	4,545	0	4,545
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	348,921	21,922	370,843	0	370,843
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	0	0	0	0
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD					
29.00 Facility Costs	0	13,302	13,302	0	13,302
30.00 Administrative Costs	30,871	9,604	40,475	0	40,475
31.00 Total Facility Overhead (sum of lines 29 and 30)	30,871	22,906	53,777	0	53,777
32.00 Total facility costs (sum of lines 22, 28 and 31)	379,792	44,828	424,620	0	424,620

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8618

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

				RHC III	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	348,921	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	0	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	0	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	348,921	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	17,377	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	17,377	14.00	
15.00	Medical Supplies	0	2,619	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	1,926	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	4,545	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	370,843	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	13,302	29.00	
30.00	Administrative Costs	0	40,475	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	53,777	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	424,620	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-3478

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.41	3,000	4,200	5,922		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.27	3,352	2,100	2,667		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.68	6,352		8,589	8,589	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.68	6,352			8,589	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)					671,520	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					671,520	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					233,533	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					750,997	15.00
16.00	Total overhead (sum of lines 14 and 15)					984,530	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					984,530	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					984,530	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,656,050	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-8598

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.75	2,804	4,200	3,150		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.62	1,377	2,100	1,302		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.37	4,181		4,452	4,452	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)	1.37	4,181			4,452	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)					370,628	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					370,628	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					290,815	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					683,463	15.00
16.00	Total overhead (sum of lines 14 and 15)					974,278	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					974,278	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					974,278	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,344,906	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-8618

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/28/2021 3:27 pm

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.96	820	4,200	4,032
2.00	Physician Assistant	0.00	0	0	0
3.00	Nurse Practitioner	0.01	27	2,100	21
4.00	Subtotal (sum of lines 1 through 3)	0.97	847	4,053	4,053
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.97	847		4,053
9.00	Physician Services Under Agreements		0		0
					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)				370,843
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				370,843
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				53,777
15.00	Parent provider overhead allocated to facility (see instructions)				365,836
16.00	Total overhead (sum of lines 14 and 15)				419,613
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				419,613
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				419,613
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				790,456

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323	Period: From 04/01/2020	Worksheet M-3	
		Component CCN: 14-3478	To 03/31/2021	Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,656,050	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,268	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,646,782	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,589	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)			8,589	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			191.73	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)		191.73	191.73	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,658	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	317,888	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	317,888	16.00
16.01	Total program charges (see instructions)(from contractor's records)			164,260	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			238,584	16.04
16.05	Total program cost (see instructions)		0	238,584	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			19,658	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			28,789	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			238,584	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,423	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			246,007	22.00
23.00	Allowable bad debts (see instructions)			27,702	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			18,006	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			23,122	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)			264,013	26.00
26.01	Sequestration adjustment (see instructions)			422	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			338,931	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)			-75,340	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3	
		Component CCN: 14-8598		Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,344,906	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,198	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,335,708	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,452	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,452	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			300.02	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)		300.02	300.02	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	701	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	210,314	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	210,314	16.00
16.01	Total program charges (see instructions)(from contractor's records)			82,116	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			163,429	16.04
16.05	Total program cost (see instructions)		0	163,429	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,028	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			15,150	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			163,429	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,647	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			171,076	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			171,076	26.00
26.01	Sequestration adjustment (see instructions)			274	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			268,765	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)			-97,963	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3	
		Component CCN: 14-8618		Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	RHC III	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)			790,456	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			790,456	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,053	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,053	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.03	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)		195.03	195.03	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	151	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	29,450	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	29,450	16.00
16.01	Total program charges (see instructions)(from contractor's records)			20,854	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			19,114	16.04
16.05	Total program cost (see instructions)		0	19,114	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			5,558	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			3,059	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			19,114	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			19,114	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			19,114	26.00
26.01	Sequestration adjustment (see instructions)			31	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			22,042	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)			-2,959	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		535,954	535,954	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001200	0.005500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		643	2,948	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		141	26	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		784	2,974	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		671,520	671,520	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		984,530	984,530	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001168	0.004429	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,150	4,360	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,934	7,334	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		32	141	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		60.44	52.01	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		23	116	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,390	6,033	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			9,268	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			7,423	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/28/2021 3:27 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		353,498	353,498	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001200	0.005500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		424	1,944	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		141	26	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		565	1,970	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		370,628	370,628	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		974,278	974,278	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001524	0.005315	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,485	5,178	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,050	7,148	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		30	163	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		68.33	43.85	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		24	137	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,640	6,007	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			9,198	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			7,647	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/28/2021 3:27 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		255,935	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		11/09/2020	65,101	3.01	
3.02		03/22/2021	17,895	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)		82,996	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		338,931	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		75,340	6.02	
7.00	Total Medicare program liability (see instructions)		263,591	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00		
		15101	2.00		
8.00	Name of Contractor	CGS			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/28/2021 3:27 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			106,971	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			11/09/2020	41,112	3.01
3.02			03/22/2021	120,682	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)			161,794	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			268,765	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			97,963	6.02
7.00	Total Medicare program liability (see instructions)			170,802	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-8618	Period: From 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/28/2021 3:27 pm	
		RHC III	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,355	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		03/22/2021	7,687	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,687	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		22,042	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		2,959	6.02	
7.00	Total Medicare program liability (see instructions)		19,083	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00