

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND Provider CCN:14-1329 Period: From 07/01/2020 To 06/30/2021 Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 11:22 am

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date: 11/30/2021 Time: 11:22 am
2. ☐ Manually prepared cost report
3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (14-1329) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CAMI MEGLI

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	-3,740	-621,477	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	490,966	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		284,504		0	10.00
200.00	Total	0	487,226	-336,973	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:22 am

MCRIF32 - 16.12.172.7

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:22 am	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:22 am	
			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)	N	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.				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		0		76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N			92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:22 am	
			V	XIX	
			1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	Y
				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		110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
			1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N		112.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:		148,772	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:22 am	
		1.00		2.00	
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)			140.00	
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:22 am

		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)			0171.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II		Date/Time Prepared: 11/30/2021 11:22 am	
		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		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 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 reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/20/2021	Y	09/20/2021
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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 11:22 am			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	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.	Y			35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-455-9706	JILL.NELSON@RSMUS.COM		43.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 11:22 am	
		3.00			
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR			41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:22 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	528.00	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	528.00	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	528.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:22 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10	0	22			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,399	0	2,035			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	178			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,409	0	2,235			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)	1,409	0	2,235	0.00	130.46	14.00
15.00	CAH visits	6,274	161	15,265			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,907	326	22,859	0.00	33.11	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	163.57	27.00
28.00	Observation Bed Days		8	154			28.00
29.00	Ambulance Trips	249					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:22 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3	0	7	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3	0	7	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1329 Component CCN:14-3981		Period: From 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/30/2021 11:22 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	303 NORTH JACKSON STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MORRISON		IL	61270
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	yes or N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	18:00	08:00	18:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	WHITESIDE			
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	18:00	08:00	18:00	08:00
		18:00		18:00	

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1329	Period: From 07/01/2020	Worksheet S-8	
		Component CCN:14-3981	To 06/30/2021	Date/Time Prepared: 11/30/2021 11:22 am	
		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	18:00	08:00	18:00
					11.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 11:22 am	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.604916	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,588,461	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			6,172,088	6.00
7.00	Medicaid cost (line 1 times line 6)			3,733,595	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,145,134	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			100,000	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 15, 17, 18 and 16)			1,245,134	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)	6,587	15,624	22,211	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,985	15,624	19,609	21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,820	4,717	9,537	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	10,907	10,907	23.00
			1.00	2.00	3.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,964,229	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			72,781	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			111,971	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,852,258	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,159,651	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,170,558	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,315,692	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet A Date/Time Prepared: 11/30/2021 11:22 am
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Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		591,781	591,781	212,792	804,573	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		201,738	201,738	319,657	521,395	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,258,113	3,258,113	-486,198	2,771,915	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	60,072	-48,149	11,923	0	11,923	5.01
5.02	00591	PERSONNEL	64,493	16,202	80,695	0	80,695	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	392,715	153,757	546,472	0	546,472	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	711,981	610,262	1,322,243	22,952	1,345,195	5.05
7.00	00700	OPERATION OF PLANT	203,642	380,292	583,934	0	583,934	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,560	41,560	0	41,560	8.00
9.00	00900	HOUSEKEEPING	147,194	21,769	168,963	0	168,963	9.00
10.00	01000	DIETARY	231,255	82,515	313,770	0	313,770	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	197,689	34,183	231,872	0	231,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,064	97,837	135,901	0	135,901	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,162	127,787	445,949	0	445,949	16.00
17.00	01700	SOCIAL SERVICE	68,909	320	69,229	0	69,229	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	416,191	26,413	442,604	0	442,604	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,724,259	180,881	1,905,140	-2,951	1,902,189	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	965,378	700,897	1,666,275	1,410	1,667,685	50.00
53.00	05300	ANESTHESIOLOGY	0	71,342	71,342	-8,016	63,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438,082	270,418	708,500	0	708,500	54.00
60.00	06000	LABORATORY	472,615	1,029,891	1,502,506	1,760	1,504,266	60.00
64.00	06400	INTRAVENOUS THERAPY	0	67,579	67,579	20,018	87,597	64.00
65.00	06500	RESPIRATORY THERAPY	63,945	90,970	154,915	-82,985	71,930	65.00
66.00	06600	PHYSICAL THERAPY	311,937	13,727	325,664	0	325,664	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,816	262	178,078	0	178,078	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,125	9,125	0	9,125	68.00
69.00	06900	ELECTROCARDIOLOGY	4,322	18,854	23,176	0	23,176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	125,356	125,356	84,405	209,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,751,768	1,751,768	0	1,751,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,710	839,840	1,000,550	0	1,000,550	73.00
76.00	03950	NEUROLOGY	1,175	64,885	66,060	0	66,060	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,166,346	1,006,671	6,173,017	117,692	6,290,709	88.00
91.00	09100	EMERGENCY	547,523	1,774,935	2,322,458	-46,897	2,275,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	69,995	1,807	71,802	0	71,802	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	196,783	55,236	252,019	-12,327	239,692	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		456,308	456,308	-456,308	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,151,253	14,127,132	27,278,385	-314,996	26,963,389	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	12,998	12,998	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	7,000	7,000	301,998	308,998	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,151,253	14,134,132	27,285,385	0	27,285,385	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1329

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

Worksheet A

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	804,573	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	521,395	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-341,811	2,430,104	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	11,923	5.01
5.02	00591	PERSONNEL	0	80,695	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-33,965	512,507	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-15,598	1,329,597	5.05
7.00	00700	OPERATION OF PLANT	0	583,934	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,560	8.00
9.00	00900	HOUSEKEEPING	0	168,963	9.00
10.00	01000	DIETARY	-64,639	249,131	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	231,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	135,901	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,426	441,523	16.00
17.00	01700	SOCIAL SERVICE	0	69,229	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-250,983	191,621	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,902,189	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-46,145	1,621,540	50.00
53.00	05300	ANESTHESIOLOGY	0	63,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-25,315	683,185	54.00
60.00	06000	LABORATORY	-15,498	1,488,768	60.00
64.00	06400	INTRAVENOUS THERAPY	0	87,597	64.00
65.00	06500	RESPIRATORY THERAPY	0	71,930	65.00
66.00	06600	PHYSICAL THERAPY	-4,285	321,379	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,078	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,125	68.00
69.00	06900	ELECTROCARDIOLOGY	-11,882	11,294	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	209,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,751,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,063	993,487	73.00
76.00	03950	NEUROLOGY	-61,088	4,972	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	6,290,709	88.00
91.00	09100	EMERGENCY	-302,759	1,972,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	0	71,802	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	239,692	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,185,457	25,777,932	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	12,998	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	308,998	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,185,457	26,099,928	200.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	447,362	1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	5,776	2.00
3.00	OPERATING ROOM	50.00	0	1,410	3.00
4.00	LABORATORY	60.00	0	1,760	4.00
	TOTALS		0	456,308	
B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	64,641	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,446	2.00
3.00	ADMINISTRATIVE & GENERAL	5.05	0	30,174	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	115,261	
C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	299,211	1.00
	TOTALS		0	299,211	
D - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	84,405	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	84,405	
F - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	20,018	0	1.00
	TOTALS		20,018	0	
G - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	469,491	1.00
	TOTALS		0	469,491	
I - MARKETING					
1.00	OTHER NON-REIMBURSABLE COST CENTERS	194.02	0	12,998	1.00
	TOTALS		0	12,998	
J - MORRISON ORTHO CLINIC					
1.00	MORRISON ORTHOPEDIC CLINIC	194.03	262,646	39,352	1.00
2.00		0.00	0	0	2.00
	TOTALS		262,646	39,352	
500.00	Grand Total: Increases		282,664	1,477,026	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	456,308	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	456,308			
	B - INSURANCE						
1.00	ADULTS & PEDIATRICS	30.00	0	2,130	12		1.00
2.00	ANESTHESIOLOGY	53.00	0	8,016	12		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	66,508	0		3.00
4.00	EMERGENCY	91.00	0	26,280	0		4.00
5.00	AMBULANCE SERVICES	95.00	0	12,327	0		5.00
	TOTALS		0	115,261			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	299,211	9		1.00
	TOTALS		0	299,211			
	D - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	821	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	82,985	0		2.00
3.00	EMERGENCY	91.00	0	599	0		3.00
	TOTALS		0	84,405			
	F - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	20,018	0	0		1.00
	TOTALS		20,018	0			
	G - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	469,491	0		1.00
	TOTALS		0	469,491			
	I - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.05	0	12,998	0		1.00
	TOTALS		0	12,998			
	J - MORRISON ORTHO CLINIC						
1.00	RURAL HEALTH CLINIC	88.00	262,646	22,645	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16,707	0		2.00
	TOTALS		262,646	39,352			
500.00	Grand Total: Decreases		282,664	1,477,026			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 11:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	214,162	0	0	0	0	1.00
2.00	Land Improvements	429,924	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,618,066	9,837,684	0	9,837,684	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,225,959	422,707	0	422,707	0	5.00
6.00	Movable Equipment	5,423,503	1,856,884	0	1,856,884	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,911,614	12,117,275	0	12,117,275	0	8.00
9.00	Reconciling Items	10,265,229	9,433,180	0	9,433,180	0	9.00
10.00	Total (line 8 minus line 9)	16,646,385	2,684,095	0	2,684,095	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	214,162	0				1.00
2.00	Land Improvements	429,924	0				2.00
3.00	Buildings and Fixtures	29,455,750	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,648,666	0				5.00
6.00	Movable Equipment	7,280,387	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	39,028,889	0				8.00
9.00	Reconciling Items	19,698,409	0				9.00
10.00	Total (line 8 minus line 9)	19,330,480	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	591,781	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	201,738	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	793,519	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	591,781				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	201,738				2.00
3.00	Total (sum of lines 1-2)	0	793,519				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,748,502	0	31,748,502	0.813462	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,280,387	0	7,280,387	0.186538	0	2.00
3.00	Total (sum of lines 1-2)	39,028,889	0	39,028,889	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	292,570	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	500,949	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	793,519	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	447,362	64,641	0	0	804,573	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,446	0	0	521,395	2.00
3.00	Total (sum of lines 1-2)	447,362	85,087	0	0	1,325,968	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1329

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00	Investment income - other (chapter 2)			0		0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,205		ADMINISTRATIVE & GENERAL	5.05	0 7.00
8.00	Television and radio service (chapter 21)			0		0.00	0 8.00
9.00	Parking lot (chapter 21)			0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-447,189				0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0		0.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0			0 12.00
13.00	Laundry and linen service			0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-56,980		DIETARY	10.00	0 14.00
15.00	Rental of quarters to employees and others			0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0 16.00
17.00	Sale of drugs to other than patients			0		0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-4,426		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00	Vending machines			0		0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist	A	-250,983		NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A		0	CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00	CATERING REVENUE	B	-7,659		DIETARY	10.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1329

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 11:22 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7	Ref.
	1.00	2.00	3.00	4.00	5.00	
33.01 LAB OTHER REVENUE	B	-15,498	LABORATORY	60.00	0	33.01
33.02 REHAB MISC REV	B	-4,285	PHYSICAL THERAPY	66.00	0	33.02
33.03 OTHER REV-A&G	B	-5,012	ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04 NONALLOWABLE DUES	B	-6,271	ADMINISTRATIVE & GENERAL	5.05	0	33.04
33.05 PATIENT TELEPHONE - SALARIES	A	-3,110	ADMINISTRATIVE & GENERAL	5.05	0	33.05
33.06 PATIENT TELEPHONE - BENEFITS	A	-771	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07 PHYSICIAN BILLING SALARIES	A	-33,965	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.07
33.08 PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-8,415	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09 PHARMACY DRUG RETAIL 340B	A	-7,063	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.10 CRNA EMPLOYEE BENEFITS	A	-58,907	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 SELF-INSURANCE EXPENSE	A	-273,718	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,185,457				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-1329

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 11:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,633,664	302,759	1,330,905	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	21,343	0	21,343	0	0	2.00
3.00	50.00	OPERATING ROOM	46,145	46,145	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	25,315	25,315	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	11,882	11,882	0	0	0	5.00
6.00	76.00	NEUROLOGY	61,088	61,088	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			1,799,437	447,189	1,352,248	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	NEUROLOGY	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	91.00	EMERGENCY	0	0	0	302,759		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	46,145		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	25,315		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	11,882		5.00
6.00	76.00	NEUROLOGY	0	0	0	61,088		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	447,189		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE PROVIDER CCN:14-1329		Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2021 11:22 am	
SPEECH PATHOLOGY		Cost		
		1.00		
PART I - GENERAL INFORMATION				
1.00	Total number of weeks worked (excluding aides) (see instructions)		32	1.00
2.00	Line 1 multiplied by 15 hours per week		480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		49	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.64	7.00
8.00	Optional travel expense rate per mile		0.56	8.00
		Supervisors	Therapists	Assistants
		1.00	2.00	3.00
				Aides
				4.00
				Trainees
				5.00
9.00	Total hours worked	0.00	73.75	0.00
10.00	AHSEA (see instructions)	98.30	78.64	58.98
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.32	39.32	29.49
12.00	Number of travel hours (provider site)	0	0	0
12.01	Number of travel hours (offsite)	0	0	0
13.00	Number of miles driven (provider site)	0	0	0
13.01	Number of miles driven (offsite)	0	0	0
1.00				
Part II - SALARY EQUIVALENCY COMPUTATION				
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		5,800	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		5,800	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		5,800	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.				
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		78.64	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		37,747	22.00
23.00	Total salary equivalency (see instructions)		37,747	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE				
Standard Travel Allowance				
24.00	Therapists (line 3 times column 2, line 11)		1,927	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		1,927	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		276	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		2,203	28.00
Optional Travel Allowance and Optional Travel Expense				
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		2,203	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE				
Standard Travel Expense				
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
Optional Travel Allowance and Optional Travel Expense				
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.				
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2021 11:22 am	
		Speech Pathology		Cost			
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.64	58.98	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						37,747 57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,203 58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0 59.00
60.00	Overtime allowance (from column 5, line 56)						0 60.00
61.00	Equipment cost (see instructions)						0 61.00
62.00	Supplies (see instructions)						0 62.00
63.00	Total allowance (sum of lines 57-62)						39,950 63.00
64.00	Total cost of outside supplier services (from your records)						9,125 64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0 65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,927 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						276 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,203 100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						276 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 101.01
101.02	Line 34 = sum of lines 27 and 31						276 101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0 102.01
102.02	Line 35 = sum of lines 31 and 32						0 102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	804,573	804,573			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	521,395		521,395		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,430,104	0	2,430,104		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	11,923	21,359	16,993	50,275	5.01
5.02	00591	PERSONNEL	80,695	5,789	18,244	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	512,507	7,218	54,632	747	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,329,597	18,560	200,527	2,502	5.05
7.00	00700	OPERATION OF PLANT	583,934	171,240	57,607	325	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,560	19,621	0	0	8.00
9.00	00900	HOUSEKEEPING	168,963	8,190	41,639	0	9.00
10.00	01000	DIETARY	249,131	23,569	65,418	357	10.00
11.00	01100	CAFETERIA	0	8,735	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	231,872	10,120	55,923	179	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,901	7,660	10,768	9,714	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	441,523	9,825	90,002	130	16.00
17.00	01700	SOCIAL SERVICE	69,229	2,254	19,493	146	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	191,621	0	50,470	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,902,189	137,626	10,664	487,760	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,621,540	34,292	198,200	12,607	50.00
53.00	05300	ANESTHESIOLOGY	63,326	0	0	1,836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,185	20,519	124,745	1,364	54.00
60.00	06000	LABORATORY	1,488,768	20,711	29,136	958	60.00
64.00	06400	INTRAVENOUS THERAPY	87,597	0	5,663	0	64.00
65.00	06500	RESPIRATORY THERAPY	71,930	0	1,938	18,089	65.00
66.00	06600	PHYSICAL THERAPY	321,379	38,446	88,241	698	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,078	7,292	50,301	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,125	1,797	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,294	0	1,665	1,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,761	0	0	682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,751,768	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	993,487	6,467	3,368	45,462	73.00
76.00	03950	NEUROLOGY	4,972	0	0	332	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,290,709	162,270	33,034	347,579	88.00
91.00	09100	EMERGENCY	1,972,802	23,200	15,912	149,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	71,802	2,431	0	19,800	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	239,692	35,382	33,130	55,666	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,777,932	804,573	521,395	2,430,104	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	12,998	0	0	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	308,998	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,099,928	804,573	521,395	2,430,104	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			PERSONNEL	CASHIERING/ACCO UNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	114,250					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,444	680,032				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	6,244	0	1,559,179	1,559,179		5.05
7.00	00700	OPERATION OF PLANT	1,786	0	814,892	51,773	866,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	61,181	3,887	29,298	8.00
9.00	00900	HOUSEKEEPING	1,291	0	220,083	13,983	12,229	9.00
10.00	01000	DIETARY	2,028	0	340,503	21,634	35,193	10.00
11.00	01100	CAFETERIA	0	0	9,546	606	13,043	11.00
13.00	01300	NURSING ADMINISTRATION	1,734	0	302,717	19,233	15,111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	334	0	164,377	10,444	11,438	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,790	0	544,270	34,580	14,671	16.00
17.00	01700	SOCIAL SERVICE	604	0	91,726	5,828	3,365	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,650	0	245,741	15,613	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,122	24,929	2,580,759	163,966	205,504	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,466	200,497	2,250,180	142,963	51,205	50.00
53.00	05300	ANESTHESIOLOGY	0	23,816	88,978	5,653	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,842	83,251	1,040,832	66,128	30,640	54.00
60.00	06000	LABORATORY	4,145	73,097	1,750,509	111,217	30,926	60.00
64.00	06400	INTRAVENOUS THERAPY	176	14,074	107,510	6,831	0	64.00
65.00	06500	RESPIRATORY THERAPY	561	2,820	95,338	6,057	0	65.00
66.00	06600	PHYSICAL THERAPY	2,736	21,845	473,345	30,074	57,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,559	8,498	245,728	15,612	10,888	67.00
68.00	06800	SPEECH PATHOLOGY	0	226	11,148	708	2,683	68.00
69.00	06900	ELECTROCARDIOLOGY	38	2,566	16,786	1,066	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,946	215,389	13,685	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,854	1,804,622	114,655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409	52,669	1,103,431	70,105	9,656	73.00
76.00	03950	NEUROLOGY	10	1,831	7,177	456	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	43,012	70,224	6,953,975	441,820	242,302	88.00
91.00	09100	EMERGENCY	4,626	30,217	2,202,574	139,938	34,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	614	1,345	96,008	6,100	3,629	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,726	10,327	377,125	23,960	52,833	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,947	680,032	25,775,629	1,538,575	866,665	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	12,998	826	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	2,303	0	311,301	19,778	0	194.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,250	680,032	26,099,928	1,559,179	866,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,366				8.00
9.00	00900	HOUSEKEEPING	0	246,295			9.00
10.00	01000	DIETARY	0	2,338	399,668		10.00
11.00	01100	CAFETERIA	0	0	263,428	286,623	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,146	0	4,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,326	0	2,114	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,414	0	17,645	16.00
17.00	01700	SOCIAL SERVICE	0	1,273	0	3,033	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,140	76,386	131,806	65,343	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,071	16,397	0	22,447	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,120	10,257	0	17,714	54.00
60.00	06000	LABORATORY	0	11,697	0	17,806	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	322	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,321	65.00
66.00	06600	PHYSICAL THERAPY	4,780	21,729	0	9,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,118	0	4,733	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,015	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	184	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,003	0	4,526	73.00
76.00	03950	NEUROLOGY	0	0	0	46	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,924	74,739	0	76,073	88.00
91.00	09100	EMERGENCY	15,117	13,111	0	21,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	0	1,373	0	2,550	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	214	973	0	9,880	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,366	246,295	395,234	286,623	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	4,434	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,366	246,295	399,668	286,623	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192,699					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	612,580				16.00
17.00	01700	SOCIAL SERVICE	0	0	112,889			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	261,354		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	20,511	112,889	0	3,557,986	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,003	195,051	0	0	2,893,889	50.00
53.00	05300	ANESTHESIOLOGY	0	33,919	0	261,354	393,695	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,506	0	0	1,241,197	54.00
60.00	06000	LABORATORY	0	60,144	0	0	1,982,299	60.00
64.00	06400	INTRAVENOUS THERAPY	0	11,580	0	0	127,075	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,320	0	0	111,888	65.00
66.00	06600	PHYSICAL THERAPY	0	17,974	0	0	639,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,992	0	0	299,997	67.00
68.00	06800	SPEECH PATHOLOGY	0	186	0	0	15,740	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,603	0	0	20,639	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,069	0	0	233,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,488	0	0	1,962,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,336	0	0	1,245,454	73.00
76.00	03950	NEUROLOGY	0	2,208	0	0	9,887	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	58,461	57,779	0	0	7,911,073	88.00
91.00	09100	EMERGENCY	1,235	31,310	0	0	2,514,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	1,107	0	0	117,178	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	8,497	0	0	473,482	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	192,699	612,580	112,889	261,354	25,750,591	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	18,258	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	331,079	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	192,699	612,580	112,889	261,354	26,099,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00560	PURCHASING RECEIVING AND STORES		5.01
5.02	00591	PERSONNEL		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.05	00590	ADMINISTRATIVE & GENERAL		5.05
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-31,431	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	31,431	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	NEUROLOGY	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
93.00	04950	WOUND CARE	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	OPHTH CLINIC	0	194.00
194.01	07951	RENTAL SPACE	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				0	1.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	21,359	0	21,359	0	5.01
5.02	00591	PERSONNEL	0	5,789	9,522	15,311	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,218	54,632	61,850	0	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	18,560	1,749	20,309	0	5.05
7.00	00700	OPERATION OF PLANT	0	171,240	0	171,240	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,621	0	19,621	0	8.00
9.00	00900	HOUSEKEEPING	0	8,190	0	8,190	0	9.00
10.00	01000	DIETARY	0	23,569	0	23,569	0	10.00
11.00	01100	CAFETERIA	0	8,735	811	9,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,120	2,889	13,009	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,660	0	7,660	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,825	0	9,825	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,254	0	2,254	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	137,626	10,664	148,290	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,292	198,200	232,492	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,519	124,745	145,264	0	54.00
60.00	06000	LABORATORY	0	20,711	29,136	49,847	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,938	1,938	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,446	0	38,446	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,292	0	7,292	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,797	0	1,797	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,665	1,665	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	6,467	3,368	9,835	0	73.00
76.00	03950	NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	162,270	33,034	195,304	0	88.00
91.00	09100	EMERGENCY	0	23,200	15,912	39,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	0	2,431	0	2,431	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	35,382	33,130	68,512	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	804,573	521,395	1,325,968	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	804,573	521,395	1,325,968	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
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Cost Center Description			PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	21,359					5.01
5.02	00591	PERSONNEL	0	15,311				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	317	461	62,628			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,063	837	0	22,209		5.05
7.00	00700	OPERATION OF PLANT	138	239	0	737	172,354	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	55	5,826	8.00
9.00	00900	HOUSEKEEPING	0	173	0	199	2,432	9.00
10.00	01000	DIETARY	152	272	0	308	6,999	10.00
11.00	01100	CAFETERIA	0	0	0	9	2,594	11.00
13.00	01300	NURSING ADMINISTRATION	76	232	0	274	3,005	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	45	0	149	2,275	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55	374	0	493	2,918	16.00
17.00	01700	SOCIAL SERVICE	62	81	0	83	669	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	489	0	222	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,049	2,026	2,296	2,336	40,869	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,354	1,134	18,453	2,036	10,183	50.00
53.00	05300	ANESTHESIOLOGY	780	0	2,194	81	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	580	515	7,669	942	6,093	54.00
60.00	06000	LABORATORY	407	555	6,734	1,584	6,150	60.00
64.00	06400	INTRAVENOUS THERAPY	0	24	1,296	97	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	75	260	86	0	65.00
66.00	06600	PHYSICAL THERAPY	297	367	2,012	428	11,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209	783	222	2,165	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	21	10	534	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5	236	15	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	290	0	456	195	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,869	1,633	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	242	189	4,852	999	1,920	73.00
76.00	03950	NEUROLOGY	14	1	169	6	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,036	5,766	6,469	6,295	48,187	88.00
91.00	09100	EMERGENCY	2,802	620	2,784	1,993	6,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	7	82	124	87	722	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	511	231	951	341	10,507	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,359	15,002	62,628	21,915	172,354	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	12	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	309	0	282	0	194.03
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)	21,359	15,311	62,628	22,209	172,354	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,502				8.00
9.00	00900	HOUSEKEEPING	0	10,994			9.00
10.00	01000	DIETARY	0	104	31,404		10.00
11.00	01100	CAFETERIA	0	0	20,699	32,848	11.00
13.00	01300	NURSING ADMINISTRATION	0	96	0	556	17,248
14.00	01400	CENTRAL SERVICES & SUPPLY	0	193	0	242	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63	0	2,022	0
17.00	01700	SOCIAL SERVICE	0	57	0	348	384
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,766	3,411	10,357	7,489	8,257
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,046	732	0	2,573	2,836
53.00	05300	ANESTHESIOLOGY	0	0	0	434	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,654	458	0	2,030	0
60.00	06000	LABORATORY	0	522	0	2,041	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	37	42
65.00	06500	RESPIRATORY THERAPY	0	0	0	266	293
66.00	06600	PHYSICAL THERAPY	1,292	970	0	1,098	1,210
67.00	06700	OCCUPATIONAL THERAPY	0	184	0	542	598
68.00	06800	SPEECH PATHOLOGY	0	45	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	134	0	519	571
76.00	03950	NEUROLOGY	0	0	0	5	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,601	3,336	0	8,718	0
91.00	09100	EMERGENCY	4,085	585	0	2,483	2,736
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	WOUND CARE	0	61	0	292	321
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	58	43	0	1,132	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,502	10,994	31,056	32,848	17,248
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
194.00	07950	OPHTH CLINIC	0	0	0	0	0
194.01	07951	RENTAL SPACE	0	0	0	0	0
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	348	0	0
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	25,502	10,994	31,404	32,848	17,248

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,691					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,750				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,938			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	711		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	527	3,938		240,611	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,140	5,017	0		297,996	50.00
53.00	05300	ANESTHESIOLOGY	0	872	0		4,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,786	0		166,991	54.00
60.00	06000	LABORATORY	0	1,546	0		69,386	60.00
64.00	06400	INTRAVENOUS THERAPY	0	298	0		1,794	64.00
65.00	06500	RESPIRATORY THERAPY	0	60	0		2,978	65.00
66.00	06600	PHYSICAL THERAPY	0	462	0		57,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	180	0		12,175	67.00
68.00	06800	SPEECH PATHOLOGY	0	5	0		2,412	68.00
69.00	06900	ELECTROCARDIOLOGY	0	67	0		2,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	105	0		1,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,118	0		7,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,114	0		20,375	73.00
76.00	03950	NEUROLOGY	0	57	0		252	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,457	1,485	0		284,654	88.00
91.00	09100	EMERGENCY	94	805	0		64,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	28	0		4,155	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	218	0		82,504	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,691	15,750	3,938	0	1,324,306	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
194.00	07950	OPHTH CLINIC	0	0	0		0	194.00
194.01	07951	RENTAL SPACE	0	0	0		0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0		360	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0		591	194.03
200.00		Cross Foot Adjustments				711	711	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,691	15,750	3,938	711	1,325,968	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00560	PURCHASING RECEIVING AND STORES		5.01
5.02	00591	PERSONNEL		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.05	00590	ADMINISTRATIVE & GENERAL		5.05
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 240,611	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 297,996	50.00
53.00	05300	ANESTHESIOLOGY	0 4,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 166,991	54.00
60.00	06000	LABORATORY	0 69,386	60.00
64.00	06400	INTRAVENOUS THERAPY	0 1,794	64.00
65.00	06500	RESPIRATORY THERAPY	0 2,978	65.00
66.00	06600	PHYSICAL THERAPY	0 57,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 12,175	67.00
68.00	06800	SPEECH PATHOLOGY	0 2,412	68.00
69.00	06900	ELECTROCARDIOLOGY	0 2,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0 1,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 7,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 20,375	73.00
76.00	03950	NEUROLOGY	0 252	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 284,654	88.00
91.00	09100	EMERGENCY	0 64,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
93.00	04950	WOUND CARE	0 4,155	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0 82,504	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0 1,324,306	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
194.00	07950	OPHTH CLINIC	0 0	194.00
194.01	07951	RENTAL SPACE	0 0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0 360	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0 591	194.03
200.00		Cross Foot Adjustments	0 711	200.00
201.00		Negative Cost Centers	0 0	201.00
202.00		TOTAL (sum lines 118 through 201)	0 1,325,968	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)		
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
									1.00
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	54,620					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		500,948				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,590,522			4.00	
5.01	00560	PURCHASING RECEIVING AND STORES	1,450	0	60,072	3,095		5.01	
5.02	00591	PERSONNEL	393	9,149	64,493	0	13,026,688	5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	490	52,490	358,750	46	392,715	5.03	
5.05	00590	ADMINISTRATIVE & GENERAL	1,260	1,680	708,871	154	711,981	5.05	
7.00	00700	OPERATION OF PLANT	11,625	0	203,642	20	203,642	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	556	0	147,194	0	147,194	9.00	
10.00	01000	DIETARY	1,600	0	231,255	22	231,255	10.00	
11.00	01100	CAFETERIA	593	779	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	687	2,776	197,689	11	197,689	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	38,064	598	38,064	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	667	0	318,162	8	318,162	16.00	
17.00	01700	SOCIAL SERVICE	153	0	68,909	9	68,909	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	178,414	0	416,191	19.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,343	10,246	1,724,259	152	1,724,259	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,328	190,426	617,140	776	965,378	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	113	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	119,853	438,082	84	438,082	54.00	
60.00	06000	LABORATORY	1,406	27,993	472,615	59	472,615	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	20,018	0	20,018	64.00	
65.00	06500	RESPIRATORY THERAPY	0	1,862	63,945	0	63,945	65.00	
66.00	06600	PHYSICAL THERAPY	2,610	0	311,937	43	311,937	66.00	
67.00	06700	OCCUPATIONAL THERAPY	495	0	177,816	0	177,816	67.00	
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	1,600	4,322	0	4,322	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42	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	439	3,236	160,710	35	160,710	73.00	
76.00	03950	NEUROLOGY	0	0	1,175	2	1,175	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,016	31,739	1,228,705	440	4,903,700	88.00	
91.00	09100	EMERGENCY	1,575	15,288	527,505	406	527,505	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
93.00	04950	WOUND CARE	165	0	69,995	1	69,995	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,402	31,831	196,783	74	196,783	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,620	500,948	8,590,522	3,095	12,764,042	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00	07950	OPHTH CLINIC	0	0	0	0	0	194.00	
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01	
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02	
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	262,646	194.03	
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)	804,573	521,395	2,430,104	50,275	114,250	202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	14.730373	1.040817	0.282882	16.243942	0.008770	203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			0	21,359	15,311	204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	6.901131	0.001175	205.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.03	5A.05	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00591 PERSONNEL						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	43,052,866					5.03
5.05	00590 ADMINISTRATIVE & GENERAL	0	-1,559,179	24,540,749			5.05
7.00	00700 OPERATION OF PLANT	0	0	814,892	39,402		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	61,181	1,332	10,562	8.00
9.00	00900 HOUSEKEEPING	0	0	220,083	556	0	9.00
10.00	01000 DIETARY	0	0	340,503	1,600	0	10.00
11.00	01100 CAFETERIA	0	0	9,546	593	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	302,717	687	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	164,377	520	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	544,270	667	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	91,726	153	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	245,741	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,578,284	0	2,580,759	9,343	4,045	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,692,926	0	2,250,180	2,328	2,918	50.00
53.00	05300 ANESTHESIOLOGY	1,507,797	0	88,978	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,270,700	0	1,040,832	1,393	685	54.00
60.00	06000 LABORATORY	4,627,850	0	1,750,509	1,406	0	60.00
64.00	06400 INTRAVENOUS THERAPY	891,043	0	107,510	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	178,527	0	95,338	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,383,060	0	473,345	2,610	535	66.00
67.00	06700 OCCUPATIONAL THERAPY	538,021	0	245,728	495	0	67.00
68.00	06800 SPEECH PATHOLOGY	14,301	0	11,148	122	0	68.00
69.00	06900 ELECTROCARDIOLOGY	162,488	0	16,786	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	313,107	0	215,389	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,346,278	0	1,804,622	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,334,530	0	1,103,431	439	0	73.00
76.00	03950 NEUROLOGY	115,910	0	7,177	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	4,445,935	0	6,953,975	11,016	663	88.00
91.00	09100 EMERGENCY	1,913,099	0	2,202,574	1,575	1,692	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 WOUND CARE	85,170	0	96,008	165	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	653,840	0	377,125	2,402	24	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	43,052,866	-1,559,179	24,216,450	39,402	10,562	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950 OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951 RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952 OTHER NON-REIMBURSABLE COST CENTERS	0	0	12,998	0	0	194.02
194.03	07953 MORRISON ORTHOPEDIC CLINIC	0	0	311,301	0	0	194.03
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)	680,032		1,559,179	866,665	94,366	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.015795		0.063534	21.995457	8.934482	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	62,628		22,209	172,354	25,502	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001455		0.000905	4.374245	2.414505	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00500	PURCHASING RECEIVING AND STORES					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	29,606				9.00
10.00	01000	DIETARY	281	21,632			10.00
11.00	01100	CAFETERIA	0	14,258	12,475		11.00
13.00	01300	NURSING ADMINISTRATION	258	0	211	123,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	92	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	170	0	768	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	132	2,753	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,182	7,134	2,844	59,154	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,971	0	977	20,321	50.00
53.00	05300	ANESTHESIOLOGY	0	0	165	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,233	0	771	0	54.00
60.00	06000	LABORATORY	1,406	0	775	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14	299	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	101	2,102	65.00
66.00	06600	PHYSICAL THERAPY	2,612	0	417	8,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	206	4,284	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8	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	361	0	197	4,094	73.00
76.00	03950	NEUROLOGY	0	0	2	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,984	0	3,311	0	88.00
91.00	09100	EMERGENCY	1,576	0	943	19,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	WOUND CARE	165	0	111	2,303	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	117	0	430	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,606	21,392	12,475	123,586	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	240	0	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	0	0	194.03
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)	246,295	399,668	286,623	344,055	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.319091	18.475777	22.975792	2.783932	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,994	31,404	32,848	17,248	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.371344	1.451738	2.633106	0.139563	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1329

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00500	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,136,659		16.00
17.00	01700	SOCIAL SERVICE	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,578,284	100	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,009,017	0	50.00
53.00	05300	ANESTHESIOLOGY	2,609,994	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,348,290	0	54.00
60.00	06000	LABORATORY	4,627,850	0	60.00
64.00	06400	INTRAVENOUS THERAPY	891,043	0	64.00
65.00	06500	RESPIRATORY THERAPY	178,527	0	65.00
66.00	06600	PHYSICAL THERAPY	1,383,060	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	538,021	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,301	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,286	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	313,107	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,346,278	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,334,530	0	73.00
76.00	03950	NEUROLOGY	169,927	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,445,935	0	88.00
91.00	09100	EMERGENCY	2,409,199	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	92.00
93.00	04950	WOUND CARE	85,170	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	653,840	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,136,659	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OPHTH CLINIC	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953	MORRISON ORTHOPEDIC CLINIC	0	0	194.03
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)	612,580	112,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.012996	1,128.890000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,750	3,938	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000334	39.380000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

		Description	Worksheet		Amount	
			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
7.00		IV THERAPY		1 30.00	-31,431	7.00
8.00		IV THERAPY		1 64.00	31,431	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
					Total Costs	Total Costs
					RCE Disallowance	
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,526,555		3,526,555	0
						0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,893,889		2,893,889	0
53.00	05300	ANESTHESIOLOGY	393,695		393,695	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,241,197		1,241,197	0
60.00	06000	LABORATORY	1,982,299		1,982,299	0
64.00	06400	INTRAVENOUS THERAPY	158,506		158,506	0
65.00	06500	RESPIRATORY THERAPY	111,888	0	111,888	0
66.00	06600	PHYSICAL THERAPY	639,025	0	639,025	0
67.00	06700	OCCUPATIONAL THERAPY	299,997	0	299,997	0
68.00	06800	SPEECH PATHOLOGY	15,740	0	15,740	0
69.00	06900	ELECTROCARDIOLOGY	20,639		20,639	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	233,143		233,143	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,765		1,962,765	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,245,454		1,245,454	0
76.00	03950	NEUROLOGY	9,887		9,887	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,911,073		7,911,073	0
91.00	09100	EMERGENCY	2,514,179		2,514,179	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	243,529		243,529	0
93.00	04950	WOUND CARE	117,178		117,178	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	473,482		473,482	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	25,994,120	0	25,994,120	0
201.00		Less Observation Beds	243,529		243,529	0
202.00		Total (see instructions)	25,750,591	0	25,750,591	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet C
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			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	1,087,714		1,087,714		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	12,623,755	12,623,755	0.229242	50.00
53.00	05300	ANESTHESIOLOGY	0	1,499,264	1,499,264	0.262592	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,445	5,130,990	5,172,435	0.239964	54.00
60.00	06000	LABORATORY	124,987	4,421,210	4,546,197	0.436035	60.00
64.00	06400	INTRAVENOUS THERAPY	305,609	588,220	893,829	0.177334	64.00
65.00	06500	RESPIRATORY THERAPY	141,791	36,575	178,366	0.627294	65.00
66.00	06600	PHYSICAL THERAPY	635,993	724,084	1,360,077	0.469845	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,904	98,119	537,023	0.558630	67.00
68.00	06800	SPEECH PATHOLOGY	9,825	4,476	14,301	1.100622	68.00
69.00	06900	ELECTROCARDIOLOGY	3,233	157,531	160,764	0.128381	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,918	183,533	311,451	0.748570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,325,291	3,325,291	0.590254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,389	2,465,262	3,231,651	0.385392	73.00
76.00	03950	NEUROLOGY	0	115,910	115,910	0.085299	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	97,860	4,291,866	4,389,726		88.00
91.00	09100	EMERGENCY	0	1,893,425	1,893,425	1.327847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	490,571	490,571	0.496419	92.00
93.00	04950	WOUND CARE	4,868	80,015	84,883	1.380465	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	652,227	652,227	0.725947	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	3,786,536	38,782,324	42,568,860		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	3,786,536	38,782,324	42,568,860		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Worksheet C
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,087,714		1,087,714			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	12,623,755	12,623,755	0.229242	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	1,499,264	1,499,264	0.262592	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,445	5,130,990	5,172,435	0.239964	0.000000	54.00
60.00	06000	LABORATORY	124,987	4,421,210	4,546,197	0.436035	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	305,609	588,220	893,829	0.177334	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	141,791	36,575	178,366	0.627294	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	635,993	724,084	1,360,077	0.469845	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,904	98,119	537,023	0.558630	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,825	4,476	14,301	1.100622	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,233	157,531	160,764	0.128381	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,918	183,533	311,451	0.748570	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,325,291	3,325,291	0.590254	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,389	2,465,262	3,231,651	0.385392	0.000000	73.00
76.00	03950	NEUROLOGY	0	115,910	115,910	0.085299	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	97,860	4,291,866	4,389,726	1.802179	0.000000	88.00
91.00	09100	EMERGENCY	0	1,893,425	1,893,425	1.327847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	490,571	490,571	0.496419	0.000000	92.00
93.00	04950	WOUND CARE	4,868	80,015	84,883	1.380465	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	652,227	652,227	0.725947	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,786,536	38,782,324	42,568,860			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,786,536	38,782,324	42,568,860			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1329

Period:
From 07/01/2020
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 NEUROLOGY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04950 WOUND CARE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/30/2021 11:22 am
Title XVIII				Hospital		Cost
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	297,996	12,623,755	0.023606	0	0	50.00
53.00 05300 ANESTHESIOLOGY	4,361	1,499,264	0.002909	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	166,991	5,172,435	0.032285	0	0	54.00
60.00 06000 LABORATORY	69,386	4,546,197	0.015262	2,117	32	60.00
64.00 06400 INTRAVENOUS THERAPY	1,794	893,829	0.002007	1,454	3	64.00
65.00 06500 RESPIRATORY THERAPY	2,978	178,366	0.016696	0	0	65.00
66.00 06600 PHYSICAL THERAPY	57,999	1,360,077	0.042644	119	5	66.00
67.00 06700 OCCUPATIONAL THERAPY	12,175	537,023	0.022671	131	3	67.00
68.00 06800 SPEECH PATHOLOGY	2,412	14,301	0.168660	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	2,009	160,764	0.012497	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,046	311,451	0.003358	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7,620	3,325,291	0.002292	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20,375	3,231,651	0.006305	4,951	31	73.00
76.00 03950 NEUROLOGY	252	115,910	0.002174	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	284,654	4,389,726	0.064846	0	0	88.00
91.00 09100 EMERGENCY	64,988	1,893,425	0.034323	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16,615	490,571	0.033869	0	0	92.00
93.00 04950 WOUND CARE	4,155	84,883	0.048950	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1,017,806	40,828,919		8,772	74	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Cost
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	261,354	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950 WOUND CARE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	261,354	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	12,623,755	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0	261,354	0	1,499,264	0.174322	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	5,172,435	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	4,546,197	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	893,829	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	178,366	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	1,360,077	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	537,023	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	14,301	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	160,764	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	311,451	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,325,291	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,231,651	0.000000	73.00
76.00	03950 NEUROLOGY	0	0	0	115,910	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	4,389,726	0.000000	88.00
91.00	09100 EMERGENCY	0	0	0	1,893,425	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	490,571	0.000000	92.00
93.00	04950 WOUND CARE	0	0	0	84,883	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	261,354	0	40,828,919		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1329

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	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	0	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	2,117	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	1,454	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	119	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	131	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,951	0	0	0	73.00
76.00	03950 NEUROLOGY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950 WOUND CARE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		8,772	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 11:22 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.229242	0	2,903,571	0	50.00
53.00	05300	ANESTHESIOLOGY	0.262592	0	407,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239964	0	1,394,822	0	54.00
60.00	06000	LABORATORY	0.436035	0	926,448	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.177334	0	198,580	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.627294	0	9,045	0	65.00
66.00	06600	PHYSICAL THERAPY	0.469845	0	186,432	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.558630	0	37,533	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.100622	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.128381	0	58,222	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.748570	0	49,830	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.590254	0	1,158,550	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385392	0	579,352	0	73.00
76.00	03950	NEUROLOGY	0.085299	0	15,505	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	1.327847	0	379,778	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.496419	0	134,341	0	92.00
93.00	04950	WOUND CARE	1.380465	0	38,749	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.725947		0		95.00
200.00		Subtotal (see instructions)		0	8,478,407	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
202.00		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	8,478,407	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
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			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	665,620	0		50.00
53.00	05300	ANESTHESIOLOGY	107,045	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	334,707	0		54.00
60.00	06000	LABORATORY	403,964	0		60.00
64.00	06400	INTRAVENOUS THERAPY	35,215	0		64.00
65.00	06500	RESPIRATORY THERAPY	5,674	0		65.00
66.00	06600	PHYSICAL THERAPY	87,594	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,967	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	7,475	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,301	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	683,839	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,278	0		73.00
76.00	03950	NEUROLOGY	1,323	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	504,287	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,689	0		92.00
93.00	04950	WOUND CARE	53,492	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,238,470	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,238,470	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 THROUGH COSTS

Provider CCN:14-1329

Period:

Worksheet D

Component CCN:14-Z329

From 07/01/2020

Part IV

To 06/30/2021

Date/Time Prepared:

11/30/2021 11:22 am

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	261,354	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 NEUROLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950 WOUND CARE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	261,354	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN:14-1329 Period: From 07/01/2020 Worksheet D
THROUGH COSTS Component CCN:14-Z329 To 06/30/2021 Part IV
Date/Time Prepared: 11/30/2021 11:22 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	12,623,755	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0	261,354	0	1,499,264	0.174322	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	5,172,435	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	4,546,197	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	893,829	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	178,366	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	1,360,077	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	537,023	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	14,301	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	160,764	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	311,451	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,325,291	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,231,651	0.000000	73.00
76.00	03950 NEUROLOGY	0	0	0	115,910	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	4,389,726	0.000000	88.00
91.00	09100 EMERGENCY	0	0	0	1,893,425	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	490,571	0.000000	92.00
93.00	04950 WOUND CARE	0	0	0	84,883	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	261,354	0	40,828,919		200.00

Health Financial Systems			MORRISON COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1329 Component CCN:14-Z329		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 11:22 am	
				Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	33,047	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	64,290	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	296,980	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	99,669	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	421,616	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	287,572	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,174	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,293	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	79,984	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	267,510	0	0	0	0	73.00
76.00	03950	NEUROLOGY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.00	04950	WOUND CARE	0.000000	3,289	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		1,561,424	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:

Worksheet D

Component CCN:14-Z329

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:

11/30/2021 11:22 am

		Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description		Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.229242	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.262592	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239964	0	0	0	54.00
60.00	06000	LABORATORY	0.436035	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.177334	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.627294	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.469845	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.558630	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.100622	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.128381	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.748570	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.590254	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385392	0	0	0	73.00
76.00	03950	NEUROLOGY	0.085299	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	1.327847	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.496419	0	0	0	92.00
93.00	04950	WOUND CARE	1.380465	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.725947		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1329

Period:

Worksheet D

Component CCN:14-Z329

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 11:22 am

				Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	NEUROLOGY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,389	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		176	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)		22	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,018	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)		1,017	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		89	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)		89	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10	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)		700	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)		699	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		169.71	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		169.71	20.00	
21.00	Total general inpatient routine service cost (see instructions)		3,526,555	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)		15,104	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)		15,104	25.00	
26.00	Total swing-bed cost (see instructions)		3,248,235	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		278,320	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)		278,320	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,581.34	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,813	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)		15,813	41.00	

Health Financial Systems		MORRISON COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/30/2021 11:22 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				Total Inpatient	Total	Average Per	Program Days	Program Cost	
				Cost	Inpatient Days	diem (col. 1 ÷ col. 2)		(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)			3,218					
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)			19,031					
PASS THROUGH COST ADJUSTMENTS									
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)			0					
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)			0					
52.00	Total Program excludable cost (sum of lines 50 and 51)			0					
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)			0					
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges			0					
55.00	Target amount per discharge			0.00					
56.00	Target amount (line 54 x line 55)			0					
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)			0					
58.00	Bonus payment (see instructions)			0					
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket			0.00					
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket			0.00					
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)			0					
62.00	Relief payment (see instructions)			0					
63.00	Allowable Inpatient cost plus incentive payment (see instructions)			0					
PROGRAM INPATIENT ROUTINE SWING BED COST									
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)			1,106,938					
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)			1,105,357					
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH			2,212,295					
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			0					
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)			0					
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			0					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY									
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)								
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)								
72.00	Program routine service cost (line 9 x line 71)								
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)								
74.00	Total Program general inpatient routine service costs (line 72 + line 73)								
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)								
76.00	Per diem capital-related costs (line 75 ÷ line 2)								
77.00	Program capital-related costs (line 9 x line 76)								
78.00	Inpatient routine service cost (line 74 minus line 77)								
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)								
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								
81.00	Inpatient routine service cost per diem limitation								
82.00	Inpatient routine service cost limitation (line 9 x line 81)								
83.00	Reasonable inpatient routine service costs (see instructions)								
84.00	Program inpatient ancillary services (see instructions)								
85.00	Utilization review - physician compensation (see instructions)								
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)								
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)			154					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			1,581.36					
89.00	Observation bed cost (line 87 x line 88) (see instructions)			243,529					

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-1329

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 11:22 am

		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	240,611	3,526,555	0.068228	243,529	16,615
91.00	Nursing School cost	0	3,526,555	0.000000	243,529	0
92.00	Allied health cost	0	3,526,555	0.000000	243,529	0
93.00	All other Medical Education	0	3,526,555	0.000000	243,529	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1329

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

Worksheet D-3

Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		10,930		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.229242	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.262592	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239964	0	0	54.00
60.00	06000 LABORATORY	0.436035	2,117	923	60.00
64.00	06400 INTRAVENOUS THERAPY	0.177334	1,454	258	64.00
65.00	06500 RESPIRATORY THERAPY	0.627294	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.469845	119	56	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.558630	131	73	67.00
68.00	06800 SPEECH PATHOLOGY	1.100622	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.128381	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.748570	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.590254	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.385392	4,951	1,908	73.00
76.00	03950 NEUROLOGY	0.085299	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.327847	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496419	0	0	92.00
93.00	04950 WOUND CARE	1.380465	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)		8,772	3,218	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		8,772		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1329

Period:

Worksheet D-3

Component CCN:14-Z329

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.229242	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.262592	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.239964	33,047	7,930	54.00
60.00	06000 LABORATORY	0.436035	64,290	28,033	60.00
64.00	06400 INTRAVENOUS THERAPY	0.177334	296,980	52,665	64.00
65.00	06500 RESPIRATORY THERAPY	0.627294	99,669	62,522	65.00
66.00	06600 PHYSICAL THERAPY	0.469845	421,616	198,094	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.558630	287,572	160,646	67.00
68.00	06800 SPEECH PATHOLOGY	1.100622	6,174	6,795	68.00
69.00	06900 ELECTROCARDIOLOGY	0.128381	1,293	166	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.748570	79,984	59,874	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.590254	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.385392	267,510	103,096	73.00
76.00	03950 NEUROLOGY	0.085299	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	1.327847	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496419	0	0	92.00
93.00	04950 WOUND CARE	1.380465	3,289	4,540	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)		1,561,424	684,361	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)		1,561,424		202.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			3,238,470	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)			3,238,470	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)			3,270,855	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)			16,679	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,517,792	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,736,384	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1,736,384	30.00
31.00	Primary payer payments			463	31.00
32.00	Subtotal (line 30 minus line 31)			1,735,921	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)			87,594	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			56,936	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			61,160	36.00
37.00	Subtotal (see instructions)			1,792,857	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			1,792,857	40.00
40.01	Sequestration adjustment (see instructions)			0	40.01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0	40.03
41.00	Interim payments			2,414,334	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)			-621,477	43.00
43.01	Balance due provider/program-PARHM (see instructions)			0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN:14-1329		Period: From 07/01/2020 To 06/30/2021	
		Title XVIII		Hospital	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		22,771		2,330,027
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	02/03/2021	84,307
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		84,307
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)		22,771		2,414,334
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		3,740		621,477
7.00	Total Medicare program liability (see instructions)		19,031		1,792,857
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN:14-1329	Period: From 07/01/2020	Worksheet E-1	
		Component CCN:14-Z329	To 06/30/2021	Part I Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	Swing Beds - SNF	Cost	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,269,779		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/03/2021	122,168		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		122,168		0
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)		2,391,947		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		490,966		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,882,913		0
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 11:22 am

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

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1329	Period: From 07/01/2020	Worksheet E-2	
		Component CCN:14-Z329	To 06/30/2021	Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,234,418	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-3, col. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	Part 691,205		0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days	1,399		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		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,925,623		0	8.00
9.00	Primary payer payments (see instructions)	0		0	9.00
10.00	Subtotal (line 8 minus line 9)	2,925,623		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		0	11.00
12.00	Subtotal (line 10 minus line 11)	2,925,623		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	42,710		0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)	2,882,913		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)	2,882,913		0	19.00
19.01	Sequestration adjustment (see instructions)	0		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		0	19.25
20.00	Interim payments	2,391,947		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)	490,966		0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			19,031	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)			19,031	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			19,031	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)			19,031	19.00
20.00	Deductibles (exclude professional component)			0	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			19,031	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			19,031	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			19,031	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)			19,031	30.00
30.01	Sequestration adjustment (see instructions)			0	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			22,771	31.00
31.01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)				32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			-3,740	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)				33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	34.00

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

Provider CCN:14-1329

Period:

Worksheet G

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/30/2021 11:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,478,486	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	7,293,466	0	0	0	4.00
5.00	Other receivable	1,144,922	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	495,644	0	0	0	7.00
8.00	Prepaid expenses	161,786	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)	18,574,304	0	0	0	11.00
FIXED ASSETS						
12.00	Land	214,162	0	0	0	12.00
13.00	Land improvements	429,924	0	0	0	13.00
14.00	Accumulated depreciation	-343,930	0	0	0	14.00
15.00	Buildings	29,607,627	0	0	0	15.00
16.00	Accumulated depreciation	-6,659,084	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,648,666	0	0	0	19.00
20.00	Accumulated depreciation	-1,002,945	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	7,280,387	0	0	0	23.00
24.00	Accumulated depreciation	-4,984,174	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,190,633	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	548	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	548	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,765,485	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,783,523	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,078,237	0	0	0	38.00
39.00	Payroll taxes payable	560,596	0	0	0	39.00
40.00	Notes and loans payable (short term)	348,531	0	0	0	40.00
41.00	Deferred income	524,050	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	313,586	0	0	0	43.00
44.00	Other current liabilities	2,023,977	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,632,500	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,092,286	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,779,139	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,871,425	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,503,925	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,261,560	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,261,560	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,765,485	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-1329

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 11:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,847,305		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,414,255				2.00
3.00	Total (sum of line 1 and line 2)		14,261,560		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)		14,261,560		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,261,560		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN:14-1329

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 11:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	528,559		528,559	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,044,792		1,044,792	5.00
6.00	Swing bed - NF	11,081		11,081	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)	1,584,432		1,584,432	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)	1,584,432		1,584,432	17.00
18.00	Ancillary services	2,442,600	35,515,483	37,958,083	18.00
19.00	Outpatient services	4,868	2,505,508	2,510,376	19.00
20.00	RURAL HEALTH CLINIC	97,860	4,413,274	4,511,134	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	653,840	653,840	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	G-3, 4,129,760	43,088,105	47,217,865	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,285,385		29.00
30.00	CHARITY CARE RHC SLIDING FEE	2,215			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)		2,215		36.00
37.00	INTEREST EXPENSE	456,308			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)		456,308		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,831,292		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/30/2021 11:22 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	47,217,865	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,580,896	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,636,969	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,831,292	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,805,677	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,005	6.00
7.00	Income from investments	8,202	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	143,064	24.00
24.01	COUNTY TAX REVENUE	1,048,549	24.01
24.02	STATE TAX REVENUE	119,834	24.02
24.03	PROVIDER RELIEF FUND GRANT REVENUE	1,555,488	24.03
24.04	GAIN ON DISPOSAL OF ASSETS	183,744	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,064,886	25.00
26.00	Total (line 5 plus line 25)	5,870,563	26.00
27.00	INTEREST EXPENSE	456,308	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	456,308	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,414,255	29.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN:14-1329 Component CCN:14-3981		Period: From 07/01/2020 To 06/30/2021		Worksheet M-1 Date/Time Prepared: 11/30/2021 11:22 am	
				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	3,425,606	0	3,425,606	-231,540	3,194,066	1.00
2.00	Physician Assistant	138,800	0	138,800	0	138,800	2.00
3.00	Nurse Practitioner	503,702	0	503,702	-16,978	486,724	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	181,284	0	181,284	0	181,284	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	878,491	0	878,491	-36,773	841,718	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,127,883	0	5,127,883	-285,291	4,842,592	10.00
11.00	Physician Services Under Agreement	0	717,158	717,158	0	717,158	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	717,158	717,158	0	717,158	14.00
15.00	Medical Supplies	0	51,136	51,136	0	51,136	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	66,508	66,508	-66,508	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	117,644	117,644	-66,508	51,136	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,127,883	834,802	5,962,685	-351,799	5,610,886	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	38,463	0	38,463	0	38,463	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)	38,463	0	38,463	0	38,463	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	64,124	64,124	0	64,124	29.00
30.00	Administrative Costs	0	107,745	107,745	469,491	577,236	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	171,869	171,869	469,491	641,360	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,166,346	1,006,671	6,173,017	117,692	6,290,709	32.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provider CCN:14-1329	Period: From 07/01/2020	Worksheet M-1
			Component CCN:14-3981	To 06/30/2021	Date/Time Prepared: 11/30/2021 11:22 am
			RHC I		Cost
			Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
			6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	3,194,066		1.00
2.00	Physician Assistant	0	138,800		2.00
3.00	Nurse Practitioner	0	486,724		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	181,284		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	841,718		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,842,592		10.00
11.00	Physician Services Under Agreement	0	717,158		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	717,158		14.00
15.00	Medical Supplies	0	51,136		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	51,136		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	5,610,886		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	38,463		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	38,463		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	64,124		29.00
30.00	Administrative Costs	0	577,236		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	641,360		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	6,290,709		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1329 Component CCN:14-3981		Period: From 07/01/2020 To 06/30/2021		Worksheet M-2 Date/Time Prepared: 11/30/2021 11:22 am	
			RHC I		Cost			
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	6.15	13,430	2,184	13,432			1.00
2.00	Physician Assistant	0.85	623	714	607			2.00
3.00	Nurse Practitioner	4.02	6,238	1,533	6,163			3.00
4.00	Subtotal (sum of lines 1 through 3)	11.02	20,291		20,202		20,291	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	2.24	2,568				2,568	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)	13.26	22,859				22,859	8.00
9.00	Physician Services Under Agreements		0				0	9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						5,610,886	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						38,463	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						5,649,349	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.993192	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						641,360	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						1,620,364	15.00
16.00	Total overhead (sum of lines 14 and 15)						2,261,724	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						2,261,724	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						2,246,326	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						7,857,212	20.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3	
		Component CCN:14-3981		Date/Time Prepared: 11/30/2021 11:22 am	
		Title XVIII	RHC I	Cost	
			1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,857,212	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			58,609	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,798,603	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,859	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)			22,859	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			341.16	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	227.00	8.00
9.00	Rate for Program covered visits (see instructions)	341.16	341.16	227.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,497	1,212	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	851,877	275,124	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	169	29	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	57,656	6,583	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	57,656	6,583	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	1,191,240		16.00
16.01	Total program charges (see instructions)(from contractor's records)		816,023		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,849		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,998		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.)		916,083		16.04
16.05	Total program cost (see instructions)	0	926,081		16.05
17.00	Primary payer amounts		324		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,138		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		154,607		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		925,757		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,959		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		961,716		22.00
23.00	Allowable bad debts (see instructions)		24,377		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		15,845		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,868		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.01	TELEHEALTH		0		25.01
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		977,561		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		693,057		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)		284,504		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN:14-1329

Period:

Worksheet M-4

Component CCN:14-3981

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 11:22 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,842,592	4,842,592	4,842,592	4,842,592	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000077	0.000148	0.007174	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	373	717	34,741	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,457	1,564	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,830	2,281	34,741	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,610,886	5,610,886	5,610,886	5,610,886	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,246,326	2,246,326	2,246,326	2,246,326	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000861	0.000407	0.006192	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,934	914	13,909	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,764	3,195	48,650	0	10.00
11.00	Total number of injections/infusions (from your records)	32	61	2,964	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	211.38	52.38	16.41	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	14	1,572	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			536	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	634	733	34,592	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		58,609			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		35,959			16.00

Health Financial Systems		MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1329	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5	
		Component CCN:14-3981		Date/Time Prepared: 11/30/2021 11:22 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		688,006	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		02/03/2021	5,051	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)		5,051	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		693,057	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		284,504	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		977,561	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00