

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

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND Provider CCN:14-1333 Period: Worksheet S
SETTLEMENT SUMMARY To 02/28/2021 Parts I-III Date/Time Prepared: 7/28/2021 6:09 am

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date: 7/28/2021 Time: 6:09 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 SARAH D CULBERTSON (14-1333) for the cost reporting period beginning 03/01/2020 and ending 02/28/2021 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) JOHN KESSLER

Officer or Administrator of Provider(s)

CEO

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	148,197	-696,189	0	0	1.00	
2.00	Subprovider - IPF	0	0	0		0	2.00	
3.00	Subprovider - IRF	0		0		0	3.00	
5.00	Swing Bed - SNF	0	235,888	0		0	5.00	
6.00	Swing Bed - NF	0				0	6.00	
10.00	RURAL HEALTH CLINIC I	0		437,239		0	10.00	
200.00	Total	0	384,085	-258,950	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1333		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street:238 SOUTH CONGRESS			PO Box:				1.00	
2.00	City: RUSHVILLE			State: IL		Zip Code:62681		County: SCHUYLER	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SARAH D CULBERTSON	141333	99914	1	05/01/2004	N
4.00	Subprovider - IPF							O	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			SDCMH SWING BED- SNF	14Z333	99914		05/01/2004	N
8.00	Swing Beds - NF							O	N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC			ELMER HUGH TAYLOR CLINIC	143483	99914		10/01/2006	N
16.00	Hospital-Based Health Clinic - FQHC							O	N
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						03/01/2020	02/28/2021	
21.00	Type of Control (see instructions)						11		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1333		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural Status	Date of Geographic Reclassification		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.								56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 6:09 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 6:09 am

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

Health Financial Systems		SARAH D CULBERTSON		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?			Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y	106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y	108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	109.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 am
			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
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.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	58,664	0	118.01
			1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312N and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1333		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 am	
						1.00	2.00		
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)							140.00	
						1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:				Contractor's Name:		Contractor's Number:		141.00
142.00	Street:				PO Box:				142.00
143.00	City:				State:		Zip Code:		143.00
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
						Part A	Part B	Title V	Title XIX
						1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital				N	N	N	N	155.00
156.00	Subprovider - IPF				N	N	N	N	156.00
157.00	Subprovider - IRF				N	N	N	N	157.00
158.00	SUBPROVIDER								158.00
159.00	SNF				N	N	N	N	159.00
160.00	HOME HEALTH AGENCY				N	N	N	N	160.00
161.00	CMHC					N	N	N	161.00
						1.00			
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00 166.00	
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 6:09 am
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N 0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 6:09 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N 1.00	Date 2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
			Y/N 1.00	Type 2.00
			Date 2.00	V/I 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the 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.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
			Part A Y/N 1.00	Part B Y/N 3.00
			Date 2.00	Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N	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	04/20/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N	N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N	N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 6:09 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		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	MCCLUNG		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.	641-494-2144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN:14-1333

Period:
From 03/01/2020
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 6:09 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	22	8,030	6,517.00	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)		22	8,030	6,517.00	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)		22	8,030	6,517.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 6:09 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)	178	24	286			1.00
2.00 HMO and other (see instructions)	29	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	228	0	295			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	10			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	406	24	591			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)	406	24	591	0.00	111.71	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	2,666	257	10,559	0.00	17.41	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	129.12	27.00
28.00 Observation Bed Days		0	287			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 6:09 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	56	6	169	1.00
2.00 HMO and other (see instructions)			7	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	56	6	169	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-1333 Component CCN:14-3483		Period: From 03/01/2020 To 02/28/2021		Worksheet S-8 Date/Time Prepared: 7/28/2021 6:09 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				238 S. CONGRESS		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				RUSHVILLE		IL 62681		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				yes or N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
						1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?				Y				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				30.8? Y		4		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				COMMUNITY MEDICAL CLINIC		143484		14.00
14.01					ELMER HUGH TAYLOR CLINIC		143483		14.01
14.02					RUSHVILLE FAMILY PRACTICE		148578		14.02
14.03					COMMUNITY MEDICAL CLINIC OF		148585		14.03
				TABLE GR					
				Y/N		V		XVIII	
				1.00		2.00		3.00	
15.00	Have you provided all or substantially all 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)				GME				15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				SCHUYLER				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00

Health Financial Systems		SARAH D CULBERTSON		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1333	Period: From 03/01/2020	Worksheet S-8	
		Component CCN:14-3483	To 02/28/2021	Date/Time Prepared: 7/28/2021 6:09 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	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet S-10

Date/Time Prepared:
7/28/2021 6:09 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)		0.556365	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,762,134	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,738,627	5.00
6.00	Medicaid charges		6,954,508	6.00
7.00	Medicaid cost (line 1 times line 6)		3,869,245	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)		368,484	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 16 and 17)		368,484	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			1.00	2.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,434	21,140	26,574
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,023	21,140	24,163
22.00	Payments received from patients for amounts previously written off as charity care	230	6,769	6,999
23.00	Cost of charity care (line 21 minus line 22)	2,793	14,371	17,164
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		993,925	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		252,509	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		388,477	27.01
28.00	Non-Medicare bad debt expense (see instructions)		605,448	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		472,818	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		489,982	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		858,466	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet A

Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		485,465	485,465	20,917	506,382	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		111,272	111,272	3,787	115,059	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		23,354	23,354	2,078	25,432	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		300,517	300,517	16,383	316,900	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,964,190	1,964,190	0	1,964,190	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	198,056	63,546	261,602	0	261,602	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	400,550	278,827	679,377	0	679,377	5.04
5.05	00590	OTHER ADMIN. & GENERAL	685,778	1,213,126	1,898,904	-43,219	1,855,685	5.05
6.00	00600	MAINTENANCE & REPAIRS	197,451	107,935	305,386	0	305,386	6.00
7.00	00700	OPERATION OF PLANT	65,371	174,874	240,245	0	240,245	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	31,096	31,096	36,950	68,046	7.01
9.00	00900	HOUSEKEEPING	231,265	46,200	277,465	0	277,465	9.00
10.00	01000	DIETARY	300,898	181,718	482,616	0	482,616	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	280,685	7,875	288,560	0	288,560	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,865	39,105	362,970	0	362,970	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	314,784	0	314,784	0	314,784	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	774,616	217,835	992,451	0	992,451	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	189,914	178,516	368,430	0	368,430	50.00
53.00	05300	ANESTHESIOLOGY	0	16,241	16,241	0	16,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,048	490,232	917,280	42,785	960,065	54.00
60.00	06000	LABORATORY	430,432	816,929	1,247,361	34,824	1,282,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	36,112	36,112	0	36,112	62.00
65.00	06500	RESPIRATORY THERAPY	7,081	41,089	48,170	0	48,170	65.00
66.00	06600	PHYSICAL THERAPY	245,099	123,748	368,847	-128,837	240,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,089	0	128,089	60,091	188,180	67.00
68.00	06800	SPEECH PATHOLOGY	69,206	0	69,206	68,746	137,952	68.00
69.00	06900	ELECTROCARDIOLOGY	68,320	121,976	190,296	0	190,296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,088	61,088	0	61,088	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	841,796	841,796	0	841,796	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,197,169	421,071	2,618,240	-114,559	2,503,681	88.00
90.00	09000	CLINIC	266,794	2,349,806	2,616,600	0	2,616,600	90.00
90.02	09002	GEROPSYCH	131,415	105,003	236,418	0	236,418	90.02
91.00	09100	EMERGENCY	564,620	2,154,722	2,719,342	0	2,719,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,498,506	13,005,264	21,503,770	-54	21,503,716	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	193	-99	94	54	148	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	27,813	19,324	47,137	0	47,137	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,526,512	13,024,489	21,551,001	0	21,551,001	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet A

Date/Time Prepared:
7/28/2021 6:09 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	506,382	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	-225	114,834	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	25,432	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-377	316,523	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,009,788	2,973,978	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-8,522	253,080	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-53,979	625,398	5.04
5.05	00590	OTHER ADMIN. & GENERAL	-69,308	1,786,377	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	305,386	6.00
7.00	00700	OPERATION OF PLANT	-625	239,620	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	68,046	7.01
9.00	00900	HOUSEKEEPING	0	277,465	9.00
10.00	01000	DIETARY	-72,341	410,275	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	288,560	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,131	356,839	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	314,784	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	992,451	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-123,700	244,730	50.00
53.00	05300	ANESTHESIOLOGY	0	16,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	960,065	54.00
60.00	06000	LABORATORY	0	1,282,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	36,112	62.00
65.00	06500	RESPIRATORY THERAPY	-38,000	10,170	65.00
66.00	06600	PHYSICAL THERAPY	0	240,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	188,180	67.00
68.00	06800	SPEECH PATHOLOGY	0	137,952	68.00
69.00	06900	ELECTROCARDIOLOGY	-29,480	160,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	841,796	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-6,860	2,496,821	88.00
90.00	09000	CLINIC	-689,989	1,926,611	90.00
90.02	09002	GEROPSYCH	0	236,418	90.02
91.00	09100	EMERGENCY	-212,306	2,507,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-302,055	21,201,661	118.00
NONREIMBURSABLE COST CENTERS					
192.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	148	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	194.01
194.02	07952	FOUNDATION	0	47,137	194.02
194.03	07953	OUTPATIENT MEALS	0	0	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-302,055	21,248,946	200.00

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - PROPERTY INSURANCE					
1.00 OTHER CAP REL COSTS	3.00	0	43,165		1.00
2.00 CULBERTSON GARDENS	194.00	0	54		2.00
TOTALS		0	43,219		
C - RHC EXPENSES					
1.00 RADIOLOGY-DIAGNOSTIC	54.00	42,785	0		1.00
2.00 LABORATORY	60.00	34,824	0		2.00
3.00 PLANT & HOUSEKEEPING-RHC	7.01	16,524	20,426		3.00
TOTALS		94,133	20,426		
D - THERAPY RECLASS					
1.00 OCCUPATIONAL THERAPY	67.00	36,985	23,106		1.00
2.00 SPEECH PATHOLOGY	68.00	42,312	26,434		2.00
TOTALS		79,297	49,540		
500.00 Grand Total: Increases		173,430	113,185		500.00

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - PROPERTY INSURANCE						
1.00	OTHER ADMIN. & GENERAL	5.05	0	43,219	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	43,219		
C - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	94,133	20,426	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		94,133	20,426		
D - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	79,297	49,540	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		79,297	49,540		
500.00	Grand Total: Decreases		173,430	113,185		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 6:09 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	389,864	0	0	0	0	1.00
2.00	Land Improvements	1,052,278	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,400,968	26,000	0	26,000	0	3.00
4.00	Building Improvements	0	4,186	0	4,186	0	4.00
5.00	Fixed Equipment	5,337,108	37,091	0	37,091	0	5.00
6.00	Movable Equipment	6,686,711	262,323	0	262,323	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,866,929	329,600	0	329,600	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,866,929	329,600	0	329,600	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	389,864	0				1.00
2.00	Land Improvements	1,052,278	0				2.00
3.00	Buildings and Fixtures	5,426,968	0				3.00
4.00	Building Improvements	4,186	0				4.00
5.00	Fixed Equipment	5,374,199	0				5.00
6.00	Movable Equipment	6,949,034	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19,196,529	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19,196,529	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 6:09 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	485,465	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	111,272	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	23,354	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	300,517	0	0	0	2.00
3.00	Total (sum of lines 1-2)	620,091	300,517	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	485,465				1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	111,272				1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	23,354				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	300,517				2.00
3.00	Total (sum of lines 1-2)	0	920,608				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 6:09 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	8,717,127	0	8,717,127	0.484575	20,917	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,578,318	0	1,578,318	0.087737	3,787	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	866,056	0	866,056	0.048143	2,078	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	6,827,731	0	6,827,731	0.379545	16,383	2.00
3.00	Total (sum of lines 1-2)	17,989,232	0	17,989,232	1.000000	43,165	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	20,917	485,465	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	3,787	111,047	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	2,078	23,354	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	16,383	-377	300,517	2.00
3.00	Total (sum of lines 1-2)	0	0	43,165	619,489	300,517	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	20,917	0	0	506,382	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	3,787	0	0	114,834	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	2,078	0	0	25,432	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,383	0	0	316,523	2.00
3.00	Total (sum of lines 1-2)	0	43,165	0	0	963,171	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet A-8

Date/Time Prepared:
7/28/2021 6:09 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
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0 1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0 1.02
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)	B	-13,662	0	HOSPITAL ONLY ADMIN & GENERAL	5.04	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-802	0	OTHER ADMIN. & GENERAL	5.05	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0	0		0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0	0		0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-405	0	OTHER ADMIN. & GENERAL	5.05	0 7.00
8.00	Television and radio service (chapter 21)	A	-625	0	OPERATION OF PLANT	7.00	0 8.00
9.00	Parking lot (chapter 21)		0	0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,084,285	0			0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0	0			0 12.00
13.00	Laundry and linen service		0	0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-72,041	0	DIETARY	10.00	0 14.00
15.00	Rental of quarters to employees and others		0	0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0	0		0.00	0 16.00
17.00	Sale of drugs to other than patients		0	0		0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-6,131	0	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0	0		0.00	0 19.00
20.00	Vending machines	B	-300	0	DIETARY	10.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME			0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0 26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME			0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0 26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet A-8

Date/Time Prepared:
7/28/2021 6:09 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		
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			00	30.00
30.99	Hospice (non-distinct) (see instructions)				00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A			00	9 32.00
33.00	INTEREST INCOME	B			00	0 33.00
33.01	MISCELLANEOUS INCOME	B	-11,923		00	0 33.01
33.03	MARKETING SALARY EXPENSE	A	-19,483		00	0 33.03
33.04	MARKETING BENEFITS EXPENSE	A	-6,818		00	0 33.04
33.05	MARKETING OTHER EXPENSE	A	-44,307		00	0 33.05
33.06	MARKETING OTHER EXPENSE	A			00	0 33.06
33.07	MARKETING OTHER EXPENSE	A	-6,860		00	0 33.07
33.08	MARKETING OTHER EXPENSE	A	-377		00	9 33.08
33.09	LOBBYING PORTION OF DUES	A	-420		00	0 33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	23,473		00	0 33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-8,522		00	0 33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-2,982		00	0 33.12
33.14	PATIENT COLLECTION FEES	B	-55,284		00	0 33.14
33.16	PROPERTY TAXES	A	-474		00	0 33.16
33.17	IMRF CONTRIBUTION	A	1,019,588		00	0 33.17
33.18	OPC RENT - CLINIC	B	-9,190		00	0 33.18
33.19	OPC RENT - RHC	B	-225		00	9 33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-302,055			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:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 6:09 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	50.00	OPERATING ROOM	123,700	123,700	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	76,088	0	76,088	0	0	2.00
3.00	60.00	LABORATORY	30,400	0	30,400	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	38,000	38,000	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	29,480	29,480	0	0	0	5.00
6.00	90.00	CLINIC	220,000	220,000	0	0	0	6.00
7.00	90.00	CLINIC	290,000	290,000	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	42,099	42,099	0	0	0	9.00
10.00	91.00	EMERGENCY	2,040,571	212,306	1,828,265	0	0	10.00
11.00	90.00	CLINIC	33,000	33,000	0	0	0	11.00
12.00	90.00	CLINIC	35,200	35,200	0	0	0	12.00
13.00	90.00	CLINIC	60,500	60,500	0	0	0	13.00
200.00			3,019,038	1,084,285	1,934,753		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
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	50.00	OPERATING ROOM	0	0	0	123,700		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	38,000		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	29,480		5.00
6.00	90.00	CLINIC	0	0	0	220,000		6.00
7.00	90.00	CLINIC	0	0	0	290,000		7.00
8.00	90.00	CLINIC	0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	42,099		9.00
10.00	91.00	EMERGENCY	0	0	0	212,306		10.00
11.00	90.00	CLINIC	0	0	0	33,000		11.00
12.00	90.00	CLINIC	0	0	0	35,200		12.00
13.00	90.00	CLINIC	0	0	0	60,500		13.00
200.00			0	0	0	1,084,285		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE PROVIDER CCN:14-1333		Period: From 03/01/2020 To 02/28/2021	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 6:09 am	
		Physical Therapy	Cost	
		1.00		
PART I - GENERAL INFORMATION				
1.00	Total number of weeks worked (excluding aides) (see instructions)		35	1.00
2.00	Line 1 multiplied by 15 hours per week		525	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		244	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		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00
		Supervisors	Therapists	Assistants
		1.00	2.00	3.00
				Aides
				4.00
				Trainees
				5.00
9.00	Total hours worked	0.00	1,395.00	0.00
10.00	AHSEA (see instructions)	109.25	87.40	65.55
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)	43.70	43.70	32.78
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)		121,923	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)		121,923	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)		121,923	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)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		121,923	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)		10,663	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)		10,663	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)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		10,663	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)		10,663	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 PROVIDER CCN:14-1333		Period: From 03/01/2020 To 02/28/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 6:09 am			
		Physical Therapy		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)	87.40	65.55	30.59	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)					121,923	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					10,663	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)					132,586	63.00
64.00	Total cost of outside supplier services (from your records)					121,626	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					10,663	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10,663	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					0	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					0	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:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	506,382	506,382				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	114,834	0	114,834			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	25,432	0	0	25,432		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	316,523				316,523	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,973,978	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	253,080	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	625,398	30,248	0	0	18,907	5.04
5.05	00590	OTHER ADMIN. & GENERAL	1,786,377	45,204	0	0	28,255	5.05
6.00	00600	MAINTENANCE & REPAIRS	305,386	50,829	0	0	31,772	6.00
7.00	00700	OPERATION OF PLANT	239,620	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	68,046	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	277,465	18,426	0	0	11,517	9.00
10.00	01000	DIETARY	410,275	25,057	0	0	15,662	10.00
11.00	01100	CAFETERIA	0	8,561	0	0	5,351	11.00
13.00	01300	NURSING ADMINISTRATION	288,560	1,087	0	0	679	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	356,839	21,950	0	0	13,720	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	314,784	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	992,451	54,634	0	0	34,150	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	244,730	37,468	0	0	23,420	50.00
53.00	05300	ANESTHESIOLOGY	16,241	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	960,065	29,296	0	0	18,312	54.00
60.00	06000	LABORATORY	1,282,185	13,199	0	0	8,250	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	36,112	906	0	0	566	62.00
65.00	06500	RESPIRATORY THERAPY	10,170	6,849	0	0	4,281	65.00
66.00	06600	PHYSICAL THERAPY	240,010	14,204	0	0	8,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	188,180	8,216	0	0	5,136	67.00
68.00	06800	SPEECH PATHOLOGY	137,952	4,230	0	0	2,644	68.00
69.00	06900	ELECTROCARDIOLOGY	160,816	1,386	0	0	866	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,088	14,050	0	0	8,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	841,796	6,260	0	0	3,913	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,496,821	0	114,834	25,432	0	88.00
90.00	09000	CLINIC	1,926,611	68,692	0	0	42,939	90.00
90.02	09002	GEROPSYCH	236,418	24,740	0	0	15,464	90.02
91.00	09100	EMERGENCY	2,507,036	20,890	0	0	13,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		21,201,661	506,382	114,834	25,432	316,523	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	148	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	47,137	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,248,946	506,382	114,834	25,432	316,523	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part I
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,973,978					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	69,080	322,160				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	139,709	0	814,262	814,262		5.04
5.05	00590	OTHER ADMIN. & GENERAL	239,194	0	2,099,030	83,875	2,182,905	5.05
6.00	00600	MAINTENANCE & REPAIRS	68,869	0	456,856	18,256	475,112	6.00
7.00	00700	OPERATION OF PLANT	22,801	0	262,421	10,486	272,907	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	5,763	0	73,809	2,949	76,758	7.01
9.00	00900	HOUSEKEEPING	80,663	0	388,071	15,507	403,578	9.00
10.00	01000	DIETARY	104,951	0	555,945	22,215	578,160	10.00
11.00	01100	CAFETERIA	0	0	13,912	556	14,468	11.00
13.00	01300	NURSING ADMINISTRATION	97,901	0	388,227	15,513	403,740	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,962	0	505,471	20,198	525,669	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	109,794	0	424,578	16,966	441,544	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	270,180	11,059	1,362,474	54,443	1,416,917	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	66,240	6,731	378,589	15,128	393,717	50.00
53.00	05300	ANESTHESIOLOGY	0	3,083	19,324	772	20,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,874	83,279	1,254,826	50,142	1,304,968	54.00
60.00	06000	LABORATORY	162,278	70,076	1,535,988	61,377	1,597,365	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	888	38,472	1,537	40,009	62.00
65.00	06500	RESPIRATORY THERAPY	2,470	343	24,113	964	25,077	65.00
66.00	06600	PHYSICAL THERAPY	57,830	9,653	330,576	13,209	343,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,576	3,660	262,768	10,500	273,268	67.00
68.00	06800	SPEECH PATHOLOGY	38,897	4,188	187,911	7,509	195,420	68.00
69.00	06900	ELECTROCARDIOLOGY	23,829	15,001	201,898	8,068	209,966	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,945	85,865	3,431	89,296	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	18,232	870,201	34,772	904,973	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	733,521	16,078	3,386,686	135,321	3,522,007	88.00
90.00	09000	CLINIC	93,056	51,043	2,182,341	87,204	2,269,545	90.00
90.02	09002	GEROPSYCH	45,837	1,559	324,018	12,947	336,965	90.02
91.00	09100	EMERGENCY	196,935	25,342	2,763,261	110,417	2,873,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,964,210	322,160	21,191,893	814,262	21,191,893	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	67	0	215	0	215	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	9,701	0	56,838	0	56,838	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,973,978	322,160	21,248,946	814,262	21,248,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1333

Period:
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Cost Center Description			OTHER ADMIN. GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-R HC	HOUSEKEEPING	
			5.05	6.00	7.00	7.01	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,182,905					5.05
6.00	00600	MAINTENANCE & REPAIRS	54,397	529,509				6.00
7.00	00700	OPERATION OF PLANT	31,246	0	304,153			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	8,788	0	0	85,546		7.01
9.00	00900	HOUSEKEEPING	46,206	25,668	14,744	0	490,196	9.00
10.00	01000	DIETARY	66,195	34,906	20,050	0	33,961	10.00
11.00	01100	CAFETERIA	1,656	11,926	6,850	0	11,603	11.00
13.00	01300	NURSING ADMINISTRATION	46,225	1,514	870	0	1,473	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,185	30,577	17,564	0	29,749	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	50,553	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	162,226	76,109	43,718	0	74,048	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,077	52,195	29,981	0	50,781	50.00
53.00	05300	ANESTHESIOLOGY	2,301	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	149,408	40,812	23,443	0	39,707	54.00
60.00	06000	LABORATORY	182,886	18,387	10,562	0	17,889	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,581	1,262	725	0	1,228	62.00
65.00	06500	RESPIRATORY THERAPY	2,871	9,540	5,480	0	9,282	65.00
66.00	06600	PHYSICAL THERAPY	39,361	19,788	11,366	0	19,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,287	11,446	6,575	0	11,136	67.00
68.00	06800	SPEECH PATHOLOGY	22,374	5,893	3,385	0	5,734	68.00
69.00	06900	ELECTROCARDIOLOGY	24,039	1,931	1,109	0	1,879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,224	19,573	11,243	0	19,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,612	8,720	5,009	0	8,484	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	403,237	0	0	85,546	0	88.00
90.00	09000	CLINIC	259,845	95,697	54,966	0	93,103	90.00
90.02	09002	GEROPSYCH	38,580	34,464	19,797	0	33,531	90.02
91.00	09100	EMERGENCY	329,013	29,101	16,716	0	28,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,176,373	529,509	304,153	85,546	490,196	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	25	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	6,507	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,182,905	529,509	304,153	85,546	490,196	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	733,272					10.00
11.00	01100	CAFETERIA	582,309	628,812				11.00
13.00	01300	NURSING ADMINISTRATION	0	49,563	503,385			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,712	0	730,456		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	492,097	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	99,024	123,086	199,672	63,530	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,974	45,424	15,530	0	50.00
53.00	05300	ANESTHESIOLOGY	0	8,818	0	0	492,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,739	0	32,471	0	54.00
60.00	06000	LABORATORY	0	71,821	0	31,059	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,162	5,113	282	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,725	0	10,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,805	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,298	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,825	17,526	8,471	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
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	255,814	0	88.00
90.00	09000	CLINIC	0	41,536	67,358	120,849	0	90.00
90.02	09002	GEROPSYCH	0	17,940	29,070	0	0	90.02
91.00	09100	EMERGENCY	0	85,808	139,222	192,285	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	681,333	628,812	503,385	730,456	492,097	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	6,883	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	45,056	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	733,272	628,812	503,385	730,456	492,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1333

Period:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.02	00592	HOSPITAL BUSINESS OFFICE			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL			5.04
5.05	00590	OTHER ADMIN. & GENERAL			5.05
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC			7.01
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,258,330	0	2,258,330
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	660,679	0	660,679
53.00	05300	ANESTHESIOLOGY	523,312	0	523,312
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,656,548	0	1,656,548
60.00	06000	LABORATORY	1,929,969	0	1,929,969
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,805	0	47,805
65.00	06500	RESPIRATORY THERAPY	60,807	0	60,807
66.00	06600	PHYSICAL THERAPY	478,442	0	478,442
67.00	06700	OCCUPATIONAL THERAPY	347,517	0	347,517
68.00	06800	SPEECH PATHOLOGY	240,104	0	240,104
69.00	06900	ELECTROCARDIOLOGY	275,746	0	275,746
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,379	0	149,379
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030,798	0	1,030,798
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,266,604	0	4,266,604
90.00	09000	CLINIC	3,002,899	0	3,002,899
90.02	09002	GEROPSYCH	510,347	0	510,347
91.00	09100	EMERGENCY	3,694,136	0	3,694,136
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,133,422	0	21,133,422
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
194.00	07950	CULBERTSON GARDENS	7,123	0	7,123
194.01	07951	MEDICAL ARTS BUILDING	0	0	0
194.02	07952	FOUNDATION	63,345	0	63,345
194.03	07953	OUTPATIENT MEALS	45,056	0	45,056
194.04	07954	VACANT SPACE	0	0	0
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	21,248,946	0	21,248,946

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	30,248	0	0	18,907	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	45,204	0	0	28,255	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	50,829	0	0	31,772	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	0	18,426	0	0	11,517	9.00
10.00	01000	DIETARY	0	25,057	0	0	15,662	10.00
11.00	01100	CAFETERIA	0	8,561	0	0	5,351	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,087	0	0	679	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,950	0	0	13,720	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	54,634	0	0	34,150	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	37,468	0	0	23,420	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,296	0	0	18,312	54.00
60.00	06000	LABORATORY	0	13,199	0	0	8,250	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	906	0	0	566	62.00
65.00	06500	RESPIRATORY THERAPY	0	6,849	0	0	4,281	65.00
66.00	06600	PHYSICAL THERAPY	0	14,204	0	0	8,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,216	0	0	5,136	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,230	0	0	2,644	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,386	0	0	866	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,050	0	0	8,782	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	6,260	0	0	3,913	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	114,834	25,432	0	88.00
90.00	09000	CLINIC	0	68,692	0	0	42,939	90.00
90.02	09002	GEROPSYCH	0	24,740	0	0	15,464	90.02
91.00	09100	EMERGENCY	0	20,890	0	0	13,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	506,382	114,834	25,432	316,523	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	506,382	114,834	25,432	316,523	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMIN. & GENERAL	
			2A	4.00	5.02	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	49,155	0	0	49,155		5.04
5.05	00590	OTHER ADMIN. & GENERAL	73,459	0	0	5,063	78,522	5.05
6.00	00600	MAINTENANCE & REPAIRS	82,601	0	0	1,102	1,957	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	633	1,124	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	178	316	7.01
9.00	00900	HOUSEKEEPING	29,943	0	0	936	1,662	9.00
10.00	01000	DIETARY	40,719	0	0	1,341	2,381	10.00
11.00	01100	CAFETERIA	13,912	0	0	34	60	11.00
13.00	01300	NURSING ADMINISTRATION	1,766	0	0	936	1,663	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,670	0	0	1,219	2,165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,024	1,818	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,784	0	0	3,286	5,835	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,888	0	0	913	1,621	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	47	83	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,608	0	0	3,027	5,374	54.00
60.00	06000	LABORATORY	21,449	0	0	3,705	6,578	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,472	0	0	93	165	62.00
65.00	06500	RESPIRATORY THERAPY	11,130	0	0	58	103	65.00
66.00	06600	PHYSICAL THERAPY	23,083	0	0	797	1,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,352	0	0	634	1,125	67.00
68.00	06800	SPEECH PATHOLOGY	6,874	0	0	453	805	68.00
69.00	06900	ELECTROCARDIOLOGY	2,252	0	0	487	865	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,832	0	0	207	368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,173	0	0	2,099	3,727	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	140,266	0	0	8,172	14,508	88.00
90.00	09000	CLINIC	111,631	0	0	5,264	9,346	90.00
90.02	09002	GEROPSYCH	40,204	0	0	782	1,388	90.02
91.00	09100	EMERGENCY	33,948	0	0	6,665	11,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	963,171	0	0	49,155	78,287	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0	234	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0		194.03
194.04	07954	VACANT SPACE	0	0	0	0		194.04
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)	963,171	0	0	49,155	78,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-R HC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	85,660					6.00
7.00	00700	OPERATION OF PLANT	0	1,757				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	494			7.01
9.00	00900	HOUSEKEEPING	4,152	85	0	36,778		9.00
10.00	01000	DIETARY	5,647	116	0	2,548	52,752	10.00
11.00	01100	CAFETERIA	1,929	40	0	871	41,892	11.00
13.00	01300	NURSING ADMINISTRATION	245	5	0	111	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,947	101	0	2,232	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,312	253	0	5,556	7,124	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,444	173	0	3,810	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,602	135	0	2,979	0	54.00
60.00	06000	LABORATORY	2,974	61	0	1,342	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	204	4	0	92	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,543	32	0	696	0	65.00
66.00	06600	PHYSICAL THERAPY	3,201	66	0	1,444	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,852	38	0	836	0	67.00
68.00	06800	SPEECH PATHOLOGY	953	20	0	430	0	68.00
69.00	06900	ELECTROCARDIOLOGY	312	6	0	141	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,166	65	0	1,429	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	1,411	29	0	637	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	494	0	0	88.00
90.00	09000	CLINIC	15,483	317	0	6,984	0	90.00
90.02	09002	GEROPSYCH	5,575	114	0	2,516	0	90.02
91.00	09100	EMERGENCY	4,708	97	0	2,124	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,660	1,757	494	36,778	49,016	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	495	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	3,241	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	85,660	1,757	494	36,778	52,752	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	58,738					11.00
13.00	01300	NURSING ADMINISTRATION	4,630	9,356				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,232	0	52,566			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,842		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,496	3,711	4,572		142,929	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,613	844	1,118		80,424	50.00
53.00	05300	ANESTHESIOLOGY	824	0	0		954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,141	0	2,337		74,203	54.00
60.00	06000	LABORATORY	6,709	0	2,235		45,053	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		2,030	62.00
65.00	06500	RESPIRATORY THERAPY	295	95	20		13,972	65.00
66.00	06600	PHYSICAL THERAPY	3,244	0	731		33,982	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,290	0	0		19,127	67.00
68.00	06800	SPEECH PATHOLOGY	682	0	0		10,217	68.00
69.00	06900	ELECTROCARDIOLOGY	1,011	326	610		6,010	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		28,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		18,076	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	18,409		181,849	88.00
90.00	09000	CLINIC	3,880	1,252	8,697		162,854	90.00
90.02	09002	GEROPSYCH	1,676	540	0		52,795	90.02
91.00	09100	EMERGENCY	8,015	2,588	13,837		83,816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,738	9,356	52,566	0	956,358	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		496	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		0	194.01
194.02	07952	FOUNDATION	0	0	0		234	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		3,241	194.03
194.04	07954	VACANT SPACE	0	0	0		0	194.04
200.00		Cross Foot Adjustments				2,842	2,842	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	58,738	9,356	52,566	2,842	963,171	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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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
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL		5.04
5.05	00590	OTHER ADMIN. & GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC		7.01
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	142,929
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	80,424
53.00	05300	ANESTHESIOLOGY	0	954
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,203
60.00	06000	LABORATORY	0	45,053
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,030
65.00	06500	RESPIRATORY THERAPY	0	13,972
66.00	06600	PHYSICAL THERAPY	0	33,982
67.00	06700	OCCUPATIONAL THERAPY	0	19,127
68.00	06800	SPEECH PATHOLOGY	0	10,217
69.00	06900	ELECTROCARDIOLOGY	0	6,010
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,067
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,076
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	181,849
90.00	09000	CLINIC	0	162,854
90.02	09002	GEROPSYCH	0	52,795
91.00	09100	EMERGENCY	0	83,816
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	956,358
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
194.00	07950	CULBERTSON GARDENS	0	496
194.01	07951	MEDICAL ARTS BUILDING	0	0
194.02	07952	FOUNDATION	0	234
194.03	07953	OUTPATIENT MEALS	0	3,241
194.04	07954	VACANT SPACE	0	0
200.00		Cross Foot Adjustments	0	2,842
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	963,171

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	1.02	2.00	4.00		
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,899						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	13,300					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				55,899			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	8,526,512		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	198,056		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	400,550		5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,990	0	0	4,990	685,778		5.05
6.00	00600	MAINTENANCE & REPAIRS	5,611	0	0	5,611	197,451		6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	65,371		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	16,524		7.01
9.00	00900	HOUSEKEEPING	2,034	0	0	2,034	231,265		9.00
10.00	01000	DIETARY	2,766	0	0	2,766	300,898		10.00
11.00	01100	CAFETERIA	945	0	0	945	0		11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	280,685		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	323,865		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	314,784		19.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	6,031	0	0	6,031	774,616		30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,136	0	0	4,136	189,914		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,234	0	0	3,234	469,833		54.00
60.00	06000	LABORATORY	1,457	0	0	1,457	465,256		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	0	0	100	0		62.00
65.00	06500	RESPIRATORY THERAPY	756	0	0	756	7,081		65.00
66.00	06600	PHYSICAL THERAPY	1,568	0	0	1,568	165,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	907	0	0	907	165,074		67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	111,518		68.00
69.00	06900	ELECTROCARDIOLOGY	153	0	0	153	68,320		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	0	0	1,551	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	691	0	0	691	0		73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	13,300	9,400	0	2,103,036		88.00
90.00	09000	CLINIC	7,583	0	0	7,583	266,794		90.00
90.02	09002	GEROPSYCH	2,731	0	0	2,731	131,415		90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	564,620		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,899	13,300	9,400	55,899	8,498,506		118.00
NONREIMBURSABLE COST CENTERS									
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	193		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0	27,813		194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0		194.03
194.04	07954	VACANT SPACE	0	0	0	0	0		194.04
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)	506,382	114,834	25,432	316,523	2,973,978		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.058874	8.634135	2.705532	5.662409	0.348792		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000		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:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet B-1

Date/Time Prepared:

7/28/2021 6:09 am

Cost Center Description		HOSPITAL BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMIN. & GENERAL (ACCUM. COST)	
		5.02	5A.04	5.04	5A.05	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	37,984,846				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-814,262	20,377,631		5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	2,099,030	-2,182,905	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	456,856	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	262,421	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	73,809	0	7.01
9.00	00900	HOUSEKEEPING	0	0	388,071	0	9.00
10.00	01000	DIETARY	0	0	555,945	0	10.00
11.00	01100	CAFETERIA	0	0	13,912	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	388,227	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	505,471	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	424,578	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,303,953	0	1,362,474	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	793,620	0	378,589	0	50.00
53.00	05300	ANESTHESIOLOGY	363,524	0	19,324	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,818,226	0	1,254,826	0	54.00
60.00	06000	LABORATORY	8,262,663	0	1,535,988	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	104,698	0	38,472	0	62.00
65.00	06500	RESPIRATORY THERAPY	40,455	0	24,113	0	65.00
66.00	06600	PHYSICAL THERAPY	1,138,238	0	330,576	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,600	0	262,768	0	67.00
68.00	06800	SPEECH PATHOLOGY	493,770	0	187,911	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,768,763	0	201,898	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,301	0	85,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,149,732	0	870,201	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,895,820	0	3,386,686	0	88.00
90.00	09000	CLINIC	6,018,542	0	2,182,341	0	90.00
90.02	09002	GEROPSYCH	183,843	0	324,018	0	90.02
91.00	09100	EMERGENCY	2,988,098	0	2,763,261	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,984,846	-814,262	20,377,631	-2,182,905	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-215	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	-56,838	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	194.04
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)	322,160		814,262	2,182,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008481		0.039959	0.114492	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		49,155	78,522	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002412	0.004118	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:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING-R HC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	41,959					6.00
7.00	00700	OPERATION OF PLANT	0	41,959				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	13,300			7.01
9.00	00900	HOUSEKEEPING	2,034	2,034	0	39,925		9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	22,052	10.00
11.00	01100	CAFETERIA	945	945	0	945	17,512	11.00
13.00	01300	NURSING ADMINISTRATION	120	120	0	120	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	2,423	0	2,423	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,031	6,031	0	6,031	2,978	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,136	4,136	0	4,136	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,234	3,234	0	3,234	0	54.00
60.00	06000	LABORATORY	1,457	1,457	0	1,457	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	100	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	756	756	0	756	0	65.00
66.00	06600	PHYSICAL THERAPY	1,568	1,568	0	1,568	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	907	907	0	907	0	67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	0	68.00
69.00	06900	ELECTROCARDIOLOGY	153	153	0	153	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	1,551	0	1,551	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	691	691	0	691	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	13,300	0	0	88.00
90.00	09000	CLINIC	7,583	7,583	0	7,583	0	90.00
90.02	09002	GEROPSYCH	2,731	2,731	0	2,731	0	90.02
91.00	09100	EMERGENCY	2,306	2,306	0	2,306	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,959	41,959	13,300	39,925	20,490	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	207	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,355	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	529,509	304,153	85,546	490,196	733,272	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.619676	7.248814	6.432030	12.277921	33.251950	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,660	1,757	494	36,778	52,752	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.041517	0.041874	0.037143	0.921177	2.392164	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:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet B-1

Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		11.00	13.00	16.00	19.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC					7.01
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	10,340				11.00
13.00	01300	NURSING ADMINISTRATION	815	61,438			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,097	0	2,587		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,024	24,370	225	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	460	5,544	55	0	50.00
53.00	05300	ANESTHESIOLOGY	145	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,081	0	115	0	54.00
60.00	06000	LABORATORY	1,181	0	110	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	52	624	1	0	65.00
66.00	06600	PHYSICAL THERAPY	571	0	36	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	227	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	178	2,139	30	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	906	0	88.00
90.00	09000	CLINIC	683	8,221	428	0	90.00
90.02	09002	GEROPSYCH	295	3,548	0	0	90.02
91.00	09100	EMERGENCY	1,411	16,992	681	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,340	61,438	2,587	100	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	194.04
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)	628,812	503,385	730,456	492,097	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	60.813540	8.193382	282.356397	4,920.970000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	58,738	9,356	52,566	2,842	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.680658	0.152284	20.319289	28.420000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 6:09 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,258,330		2,258,330	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	660,679		660,679	0	0	50.00
53.00	05300 ANESTHESIOLOGY	523,312		523,312	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,656,548		1,656,548	0	0	54.00
60.00	06000 LABORATORY	1,929,969		1,929,969	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	47,805		47,805	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	60,807	0	60,807	0	0	65.00
66.00	06600 PHYSICAL THERAPY	478,442	0	478,442	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	347,517	0	347,517	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	240,104	0	240,104	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	275,746		275,746	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	149,379		149,379	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	1,030,798		1,030,798	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	4,266,604		4,266,604	0	0	88.00
90.00	09000 CLINIC	3,002,899		3,002,899	0	0	90.00
90.02	09002 GEROPSYCH	510,347		510,347	0	0	90.02
91.00	09100 EMERGENCY	3,694,136		3,694,136	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	746,114		746,114	0	0	92.00
200.00	Subtotal (see instructions)	21,879,536	0	21,879,536	0	0	200.00
201.00	Less Observation Beds	746,114		746,114	0	0	201.00
202.00	Total (see instructions)	21,133,422	0	21,133,422	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
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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	713,990		713,990		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	246	793,374	793,620	0.832488	50.00
53.00	05300	ANESTHESIOLOGY	0	363,524	363,524	1.439553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,841	9,749,385	9,818,226	0.168722	54.00
60.00	06000	LABORATORY	327,288	7,935,375	8,262,663	0.233577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,961	95,737	104,698	0.456599	62.00
65.00	06500	RESPIRATORY THERAPY	289	40,166	40,455	1.503077	65.00
66.00	06600	PHYSICAL THERAPY	98,560	1,039,678	1,138,238	0.420336	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,430	347,170	431,600	0.805183	67.00
68.00	06800	SPEECH PATHOLOGY	2,960	490,810	493,770	0.486267	68.00
69.00	06900	ELECTROCARDIOLOGY	32,754	1,736,009	1,768,763	0.155898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	146,953	82,348	229,301	0.651454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	295,611	1,854,121	2,149,732	0.479501	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,895,820	1,895,820		88.00
90.00	09000	CLINIC	4,724	6,013,818	6,018,542	0.498941	90.00
90.02	09002	GEROPSYCH	0	183,843	183,843	2.775994	90.02
91.00	09100	EMERGENCY	19,438	2,968,660	2,988,098	1.236283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	589,963	589,963	1.264679	92.00
200.00		Subtotal (see instructions)	1,805,045	36,179,801	37,984,846		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,805,045	36,179,801	37,984,846		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
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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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
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
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
90.02	09002 GEROPSYCH	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,258,330		2,258,330		0	2,258,330	30.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	660,679		660,679		0	660,679	50.00
53.00	05300	ANESTHESIOLOGY	523,312		523,312		0	523,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,656,548		1,656,548		0	1,656,548	54.00
60.00	06000	LABORATORY	1,929,969		1,929,969		0	1,929,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,805		47,805		0	47,805	62.00
65.00	06500	RESPIRATORY THERAPY	60,807	0	60,807		0	60,807	65.00
66.00	06600	PHYSICAL THERAPY	478,442	0	478,442		0	478,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	347,517	0	347,517		0	347,517	67.00
68.00	06800	SPEECH PATHOLOGY	240,104	0	240,104		0	240,104	68.00
69.00	06900	ELECTROCARDIOLOGY	275,746		275,746		0	275,746	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,379		149,379		0	149,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030,798		1,030,798		0	1,030,798	73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,266,604		4,266,604		0	4,266,604	88.00
90.00	09000	CLINIC	3,002,899		3,002,899		0	3,002,899	90.00
90.02	09002	GEROPSYCH	510,347		510,347		0	510,347	90.02
91.00	09100	EMERGENCY	3,694,136		3,694,136		0	3,694,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	746,114		746,114		0	746,114	92.00
200.00		Subtotal (see instructions)	21,879,536	0	21,879,536		0	21,879,536	200.00
201.00		Less Observation Beds	746,114		746,114		0	746,114	201.00
202.00		Total (see instructions)	21,133,422	0	21,133,422		0	21,133,422	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
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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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	713,990		713,990		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	246	793,374	793,620	0.832488	50.00
53.00	05300	ANESTHESIOLOGY	0	363,524	363,524	1.439553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,841	9,749,385	9,818,226	0.168722	54.00
60.00	06000	LABORATORY	327,288	7,935,375	8,262,663	0.233577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,961	95,737	104,698	0.456599	62.00
65.00	06500	RESPIRATORY THERAPY	289	40,166	40,455	1.503077	65.00
66.00	06600	PHYSICAL THERAPY	98,560	1,039,678	1,138,238	0.420336	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,430	347,170	431,600	0.805183	67.00
68.00	06800	SPEECH PATHOLOGY	2,960	490,810	493,770	0.486267	68.00
69.00	06900	ELECTROCARDIOLOGY	32,754	1,736,009	1,768,763	0.155898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	146,953	82,348	229,301	0.651454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	295,611	1,854,121	2,149,732	0.479501	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,895,820	1,895,820	2.250532	88.00
90.00	09000	CLINIC	4,724	6,013,818	6,018,542	0.498941	90.00
90.02	09002	GEROPSYCH	0	183,843	183,843	2.775994	90.02
91.00	09100	EMERGENCY	19,438	2,968,660	2,988,098	1.236283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	589,963	589,963	1.264679	92.00
200.00		Subtotal (see instructions)	1,805,045	36,179,801	37,984,846		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,805,045	36,179,801	37,984,846		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet C
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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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
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
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
90.02	09002 GEROPSYCH	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part II Date/Time Prepared: 7/28/2021 6:09 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	80,424	793,620	0.101338	246	25	50.00
53.00 05300 ANESTHESIOLOGY	954	363,524	0.002624	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	74,203	9,818,226	0.007558	38,787	293	54.00
60.00 06000 LABORATORY	45,053	8,262,663	0.005453	86,842	474	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,030	104,698	0.019389	3,833	74	62.00
65.00 06500 RESPIRATORY THERAPY	13,972	40,455	0.345371	0	0	65.00
66.00 06600 PHYSICAL THERAPY	33,982	1,138,238	0.029855	8,000	239	66.00
67.00 06700 OCCUPATIONAL THERAPY	19,127	431,600	0.044316	4,010	178	67.00
68.00 06800 SPEECH PATHOLOGY	10,217	493,770	0.020692	1,900	39	68.00
69.00 06900 ELECTROCARDIOLOGY	6,010	1,768,763	0.003398	23,130	79	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28,067	229,301	0.122402	46,920	5,743	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,076	2,149,732	0.008408	132,406	1,113	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	181,849	1,895,820	0.095921	0	0	88.00
90.00 09000 CLINIC	162,854	6,018,542	0.027059	0	0	90.00
90.02 09002 GEROPSYCH	52,795	183,843	0.287174	0	0	90.02
91.00 09100 EMERGENCY	83,816	2,988,098	0.028050	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	47,222	589,963	0.080042	0	0	92.00
200.00 Total (lines 50 through 199)	860,651	37,270,856		346,074	8,257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		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	492,097	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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.02	09002 GEROPSYCH	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	492,097	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part IV Date/Time Prepared: 7/28/2021 6:09 am
					Title XVIII	Hospital	Cost
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	793,620	0.000000
53.00	05300	ANESTHESIOLOGY	0	492,097	0	363,524	1.353685
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,818,226	0.000000
60.00	06000	LABORATORY	0	0	0	8,262,663	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	104,698	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	40,455	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,138,238	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	431,600	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	493,770	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,768,763	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	229,301	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,149,732	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,895,820	0.000000
90.00	09000	CLINIC	0	0	0	6,018,542	0.000000
90.02	09002	GEROPSYCH	0	0	0	183,843	0.000000
91.00	09100	EMERGENCY	0	0	0	2,988,098	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	589,963	0.000000
200.00		Total (lines 50 through 199)	0	492,097	0	37,270,856	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 6:09 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	246	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	38,787	0	0	54.00
60.00	06000	LABORATORY	0.000000	86,842	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	3,833	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,010	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,900	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,130	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	46,920	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	132,406	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		346,074	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part V Date/Time Prepared: 7/28/2021 6:09 am
			Title XVIII	Hospital	Cost
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.832488	0	337,500	0	0 50.00
53.00 05300 ANESTHESIOLOGY	1.439553	0	146,454	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168722	0	3,653,962	0	0 54.00
60.00 06000 LABORATORY	0.233577	0	3,291,253	0	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.456599	0	95,737	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	1.503077	0	11,584	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.420336	0	315,095	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.805183	0	44,365	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.486267	0	34,170	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.155898	0	815,677	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.651454	0	66,649	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	0.479501	0	840,283	7,475	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
90.00 09000 CLINIC	0.498941	0	3,627,127	878	0 90.00
90.02 09002 GEROPSYCH	2.775994	0	183,833	0	0 90.02
91.00 09100 EMERGENCY	1.236283	0	937,274	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.264679	0	272,565	0	0 92.00
200.00 Subtotal (see instructions)		0	14,673,528	8,353	0 200.00
201.00 Less PBP Clinic Lab. Services-Program			0	0	201.00
201.00 Only Charges					
202.00 Net Charges (line 200 - line 201)		0	14,673,528	8,353	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2021 6:09 am

			Title XVIII	Hospital	Cost
	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	280,965	0	50.00
53.00	05300	ANESTHESIOLOGY	210,828	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	616,504	0	54.00
60.00	06000	LABORATORY	768,761	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	43,713	0	62.00
65.00	06500	RESPIRATORY THERAPY	17,412	0	65.00
66.00	06600	PHYSICAL THERAPY	132,446	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,722	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,616	0	68.00
69.00	06900	ELECTROCARDIOLOGY	127,162	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,419	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	402,917	3,584	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1,809,722	438	90.00
90.02	09002	GEROPSYCH	510,319	0	90.02
91.00	09100	EMERGENCY	1,158,736	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	344,707	0	92.00
200.00		Subtotal (see instructions)	6,519,949	4,022	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,519,949	4,022	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN:14-1333 Component CCN:14-Z333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part IV Date/Time Prepared: 7/28/2021 6:09 am
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Cost
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	492,097	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
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.02	09002 GEROPSYCH	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	492,097	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part IV Date/Time Prepared: 7/28/2021 6:09 am
				Component CCN:14-Z333		
				Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	793,620	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	0	492,097	0	363,524	1.353685	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	9,818,226	0.000000	54.00
60.00 06000 LABORATORY	0	0	0	8,262,663	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	104,698	0.000000	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	40,455	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	1,138,238	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	431,600	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	493,770	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,768,763	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	229,301	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2,149,732	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	1,895,820	0.000000	88.00
90.00 09000 CLINIC	0	0	0	6,018,542	0.000000	90.00
90.02 09002 GEROPSYCH	0	0	0	183,843	0.000000	90.02
91.00 09100 EMERGENCY	0	0	0	2,988,098	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	589,963	0.000000	92.00
200.00 Total (lines 50 through 199)	0	492,097	0	37,270,856		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1333

Period:

Worksheet D

Component CCN:14-Z333

From 03/01/2020
To 02/28/2021Part IV
Date/Time Prepared:
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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	
Title XVIII Swing Beds - SNF Cost							
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,280	0	0	54.00
60.00	06000	LABORATORY	0.000000	23,914	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,597	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	70,170	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	62,720	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,060	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	295	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	34,531	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	38,828	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	4,724	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		241,119	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part V Date/Time Prepared: 7/28/2021 6:09 am
			Component CCN:14-Z333		
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.832488	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	1.439553	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168722	0	0	0	0 54.00
60.00 06000 LABORATORY	0.233577	0	0	0	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.456599	0	0	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	1.503077	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.420336	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.805183	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.486267	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.155898	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.651454	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	0.479501	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
90.00 09000 CLINIC	0.498941	0	0	0	0 90.00
90.02 09002 GEROPSYCH	2.775994	0	0	0	0 90.02
91.00 09100 EMERGENCY	1.236283	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.264679	0	0	0	0 92.00
200.00 Subtotal (see instructions)		0	0	0	0 200.00
201.00 Less PBP Clinic Lab. Services-Program			0	0	201.00
201.00 Only Charges					
202.00 Net Charges (line 200 - line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D Part V Date/Time Prepared: 7/28/2021 6:09 am
		Component CCN:14-Z333		
		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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
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
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
90.02	09002	GEROPSYCH	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D-1 Date/Time Prepared: 7/28/2021 6:09 am
Cost Center Description		Title XVIII	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			878 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			573 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)			286 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			246 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)			49 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			8 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			2 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			178 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)			190 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)			38 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			178.59 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			178.59 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,258,330 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			1,429 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)			357 25.00
26.00	Total swing-bed cost (see instructions)			768,700 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,489,630 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)			1,489,630 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,599.71 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			462,748 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)			462,748 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D-1 Date/Time Prepared: 7/28/2021 6:09 am
			Title XVIII	Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					133,960
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					596,708
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)					493,945
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					98,789
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					592,734
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)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					287
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,599.70
89.00 Observation bed cost (line 87 x line 88) (see instructions)					746,114

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet D-1

Date/Time Prepared:
7/28/2021 6:09 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	142,929	2,258,330	0.063290	746,114	47,222
91.00	Nursing School cost	0	2,258,330	0.000000	746,114	0
92.00	Allied health cost	0	2,258,330	0.000000	746,114	0
93.00	All other Medical Education	0	2,258,330	0.000000	746,114	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet D-3 Date/Time Prepared: 7/28/2021 6:09 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		299,760		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.832488	246	205	50.00
53.00	05300 ANESTHESIOLOGY	1.439553	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168722	38,787	6,544	54.00
60.00	06000 LABORATORY	0.233577	86,842	20,284	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.456599	3,833	1,750	62.00
65.00	06500 RESPIRATORY THERAPY	1.503077	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.420336	8,000	3,363	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.805183	4,010	3,229	67.00
68.00	06800 SPEECH PATHOLOGY	0.486267	1,900	924	68.00
69.00	06900 ELECTROCARDIOLOGY	0.155898	23,130	3,606	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.651454	46,920	30,566	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.479501	132,406	63,489	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.498941	0	0	90.00
90.02	09002 GEROPSYCH	2.775994	0	0	90.02
91.00	09100 EMERGENCY	1.236283	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.264679	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		346,074	133,960	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)		346,074		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1333

Period:

Worksheet D-3

Component CCN:14-Z333

From 03/01/2020
To 02/28/2021Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
Title XVIII Swing Beds - SNF Cost					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,323		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.832488	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.439553	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168722	3,280	553	54.00
60.00	06000 LABORATORY	0.233577	23,914	5,586	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.456599	1,597	729	62.00
65.00	06500 RESPIRATORY THERAPY	1.503077	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.420336	70,170	29,495	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.805183	62,720	50,501	67.00
68.00	06800 SPEECH PATHOLOGY	0.486267	1,060	515	68.00
69.00	06900 ELECTROCARDIOLOGY	0.155898	295	46	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.651454	34,531	22,495	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.479501	38,828	18,618	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000 CLINIC	0.498941	4,724	2,357	90.00
90.02	09002 GEROPSYCH	2.775994	0	0	90.02
91.00	09100 EMERGENCY	1.236283	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.264679	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		241,119	130,895	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)		241,119		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet E Part B Date/Time Prepared: 7/28/2021 6:09 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,523,971	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)		6,523,971	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,589,211	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)		40,164	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,285,614	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,263,433	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,263,433	30.00
31.00	Primary payer payments		1,769	31.00
32.00	Subtotal (line 30 minus line 31)		4,261,664	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)		353,973	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		230,082	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		353,973	36.00
37.00	Subtotal (see instructions)		4,491,746	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,491,746	40.00
40.01	Sequestration adjustment (see instructions)		14,823	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		5,173,112	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)		-696,189	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 6:09 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		354,735		5,173,112	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	10/14/2020	47,700		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		47,700		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		402,435		5,173,112	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		148,197		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		696,189	6.02	
7.00	Total Medicare program liability (see instructions)		550,632		4,476,923	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1333

Period:

Worksheet E-1

Component CCN:14-Z333

From 03/01/2020
To 02/28/2021Part I
Date/Time Prepared:
7/28/2021 6:09 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		489,886		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		489,886		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		235,888		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		725,774		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 6:09 am
		Title XVIII	Hospital	Cost
		1.00		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet E-2
		Component CCN:14-Z333		Date/Time Prepared: 7/28/2021 6:09 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)	598,661	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	Part 132,204	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	228	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	730,865	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	730,865	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)	730,865	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,688	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	728,177	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)	728,177	0	19.00
19.01	Sequestration adjustment (see instructions)	2,403	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	489,886	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	235,888	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)	1		208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet E-3 Part V Date/Time Prepared: 7/28/2021 6:09 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		596,708	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)		596,708	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		602,675	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)		602,675	19.00
20.00	Deductibles (exclude professional component)		57,390	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		545,285	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		545,285	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		11,031	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		7,170	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,031	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		552,455	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)		552,455	30.00
30.01	Sequestration adjustment (see instructions)		1,823	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		402,435	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)		148,197	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:14-1333		Period: From 03/01/2020 To 02/28/2021		Worksheet G Date/Time Prepared: 7/28/2021 6:09 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	21,630,269	0	0	0	1.00	
2.00	Temporary investments	168,454	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	2,363,107	0	0	0	4.00	
5.00	Other receivable	1,063,417	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	569,621	0	0	0	7.00	
8.00	Prepaid expenses	43,379	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)	25,838,247	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	394,050	0	0	0	12.00	
13.00	Land improvements	1,052,394	0	0	0	13.00	
14.00	Accumulated depreciation	-851,814	0	0	0	14.00	
15.00	Buildings	5,426,968	0	0	0	15.00	
16.00	Accumulated depreciation	-4,151,672	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	12,323,232	0	0	0	19.00	
20.00	Accumulated depreciation	-9,874,157	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	0	0	0	0	23.00	
24.00	Accumulated depreciation	0	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)	4,319,001	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	5,273,526	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	3,016,050	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	8,289,576	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	38,446,824	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	443,202	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	1,239,222	0	0	0	38.00	
39.00	Payroll taxes payable	0	0	0	0	39.00	
40.00	Notes and loans payable (short term)	0	0	0	0	40.00	
41.00	Deferred income	0	0	0	0	41.00	
42.00	Accelerated payments	0	0	0	0	42.00	
43.00	Due to other funds	0	0	0	0	43.00	
44.00	Other current liabilities	3,556,735	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	5,239,159	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	0	0	0	0	46.00	
47.00	Notes payable	0	0	0	0	47.00	
48.00	Unsecured loans	4,373,542	0	0	0	48.00	
49.00	Other long term liabilities	1,506,857	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,880,399	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	11,119,558	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	27,327,266	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)	27,327,266	0	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,446,824	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet G-1

Date/Time Prepared:
7/28/2021 6:09 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		18,847,346		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,721,394				2.00
3.00	Total (sum of line 1 and line 2)		27,568,740		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)		27,568,740		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	215,215		0		0	12.00
13.00	ADJUSTMENT	26,259		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)		241,474		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,327,266		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	PRIOR PERIOD ADJUSTMENT		0				12.00
13.00	ADJUSTMENT		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:14-1333

Period:
From 03/01/2020
To 02/28/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 6:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	715,467		715,467	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	218,712		218,712	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	934,179		934,179	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)	934,179		934,179	17.00
18.00	Ancillary services	1,000,864	24,817,288	25,818,152	18.00
19.00	Outpatient services	20,634	11,538,133	11,558,767	19.00
20.00	RURAL HEALTH CLINIC	0	1,896,196	1,896,196	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CULBERTSON GARDENS	0	0	0	27.00
27.01	DIETARY	0	72,465	72,465	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	G-3, 1,955,677	38,324,082	40,279,759	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,551,001		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PATIENT COLLECT FEES-OTHER REV	55,284			37.00
38.00	INTEREST EXPENSE	13,662			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)		68,946		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,482,055		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-1333

Period:
From 03/01/2020
To 02/28/2021

Worksheet G-3

Date/Time Prepared:
7/28/2021 6:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,279,759	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,648,012	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,631,747	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,482,055	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,149,692	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	64,450	6.00
7.00	Income from investments	180,535	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 REVENUE	2,392,779	24.00
24.01	PROPERTY TAXES	690,105	24.01
24.02	NONCAPITAL GRANTS AND GIFTS	8,408	24.02
24.03	LOSS ON DISPOSAL OF ASSETS	0	24.03
24.50	COVID-19 PHE Funding	4,249,087	24.50
25.00	Total other income (sum of lines 6-24)	7,585,364	25.00
26.00	Total (line 5 plus line 25)	8,735,056	26.00
27.00	INTEREST EXPENSE	13,662	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	13,662	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,721,394	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1333

Period:

Worksheet M-1

Component CCN:14-3483

From 03/01/2020
To 02/28/2021Date/Time Prepared:
7/28/2021 6:09 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	422,803	69,600	492,403	0	492,403
2.00	Physician Assistant	86,446	0	86,446	0	86,446
3.00	Nurse Practitioner	601,026	0	601,026	0	601,026
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	620,576	0	620,576	0	620,576
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	17,640	0	17,640	0	17,640
8.00	Laboratory Technician	77,609	0	77,609	-77,609	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,826,100	69,600	1,895,700	-77,609	1,818,091
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	147,886	147,886	0	147,886
14.00	Subtotal (sum of lines 11 through 13)	0	147,886	147,886	0	147,886
15.00	Medical Supplies	0	112,545	112,545	0	112,545
16.00	Transportation (Health Care Staff)	0	1,680	1,680	0	1,680
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	114,225	114,225	0	114,225
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,826,100	331,711	2,157,811	-77,609	2,080,202
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	17,416	0	17,416	0	17,416
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	17,416	0	17,416	0	17,416
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	353,653	89,360	443,013	-36,950	406,063
31.00	Total Facility Overhead (sum of lines 29 and 30)	353,653	89,360	443,013	-36,950	406,063
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,197,169	421,071	2,618,240	-114,559	2,503,681

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1333

Period:

Worksheet M-1

Component CCN:14-3483

From 03/01/2020
To 02/28/2021Date/Time Prepared:
7/28/2021 6:09 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	492,403	1.00
2.00 Physician Assistant	0	86,446	2.00
3.00 Nurse Practitioner	0	601,026	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	620,576	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	17,640	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	0	9.00
10.00 Subtotal (sum of lines 1 through 9)	0	1,818,091	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	147,886	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	147,886	14.00
15.00 Medical Supplies	0	112,545	15.00
16.00 Transportation (Health Care Staff)	0	1,680	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	114,225	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,080,202	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	17,416	25.01
25.02 Chronic Care Management	0	0	25.02
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	17,416	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	0	0	29.00
30.00 Administrative Costs	-6,860	399,203	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-6,860	399,203	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-6,860	2,496,821	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1333 Component CCN:14-3483		Period: From 03/01/2020 To 02/28/2021		Worksheet M-2 Date/Time Prepared: 7/28/2021 6:09 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	1.00	1,935	1	1			1.00
2.00	Physician Assistant	0.66	927	1	1			2.00
3.00	Nurse Practitioner	3.50	7,530	1	4			3.00
4.00	Subtotal (sum of lines 1 through 3)	5.16	10,392		6		10,392	4.00
5.00	Visiting Nurse	0.00	0				0	5.00
6.00	Clinical Psychologist	0.00	0				0	6.00
7.00	Clinical Social Worker	0.13	167				167	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)	5.29	10,559				10,559	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)						2,080,202	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						17,416	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						2,097,618	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.991697	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						399,203	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						1,769,783	15.00
16.00	Total overhead (sum of lines 14 and 15)						2,168,986	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						2,168,986	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						2,150,977	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						4,231,179	20.00

Health Financial Systems		SARAH D CULBERTSON		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet M-3	
		Component CCN:14-3483		Date/Time Prepared: 7/28/2021 6:09 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)			4,231,179	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			127,108	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,104,071	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,559	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)			10,559	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			388.68	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		388.68	388.68	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,626	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,020,674	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	40	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	15,547	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	15,547	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	1,036,221	16.00
16.01	Total program charges (see instructions)(from contractor's records)			405,851	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			343	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			876	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.)			778,320	16.04
16.05	Total program cost (see instructions)		0	779,196	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			62,445	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			68,561	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			779,196	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			39,538	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			818,734	22.00
23.00	Allowable bad debts (see instructions)			23,473	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			15,257	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			23,473	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			833,991	26.00
26.01	Sequestration adjustment (see instructions)			2,752	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			394,000	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)			437,239	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1333 Component CCN:14-3483	Period: From 03/01/2020 To 02/28/2021	Worksheet M-4 Date/Time Prepared: 7/28/2021 6:09 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,818,091	1,818,091	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000633	0.002184	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,151	3,971	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		31,358	26,011	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		32,509	29,982	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,080,202	2,080,202	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,150,977	2,150,977	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015628	0.014413	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		33,615	31,002	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		66,124	60,984	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		252	870	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		262.40	70.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		70	302	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		18,368	21,170	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			127,108	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			39,538	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1333	Period: From 03/01/2020 To 02/28/2021	Worksheet M-5 Date/Time Prepared: 7/28/2021 6:09 am
		Component CCN:14-3483	RHC I	Cost
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		394,000	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		394,000	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		437,239	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		831,239	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	2.00	
8.00	Name of Contractor			8.00