

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 10:52 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 10:52 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title XVIII		HIT	Title XIX	
		Title V	Part A	Part B		
		1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	893,554	67,773	0	30,702
2.00	Subprovider - IPF	0	0	0	0	0
3.00	Subprovider - IRF	0	0	0	0	0
5.00	Swing Bed - SNF	0	172,265	0	0	0
6.00	Swing Bed - NF	0			0	0
10.00	RURAL HEALTH CLINIC I	0		-143,733	0	0
10.01	RURAL HEALTH CLINIC II	0		0	0	0
10.02	RURAL HEALTH CLINIC III	0		0	0	0
200.00	Total	0	1,065,819	-75,960	0	30,702

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 10:52 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 911 STACY BURK DRIVE			PO Box:				1.00		
2.00	City: FLORA			State: IL		Zip Code: 62839-0280		County: CLAY 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		CLAY COUNTY HOSPITAL	141351	99914	1	12/21/2005	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CLAY COUNTY SWING BED	142351	99914		12/21/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		CLAY COUNTY MEDICAL CLINIC	143458	99914		11/29/2005	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		LOUISVILLE MEDICAL CLINIC	143487	99914		12/18/2006	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		CLAY COUNTY HOSPITAL CLAY CITY CLINI	148558	99914		09/02/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						03/01/2020	02/28/2021		20.00
21.00	Type of Control (see instructions)						9			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	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.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 10:52 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 10:52 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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To 02/28/2021Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					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)					71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 10:52 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.			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 1.00	XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 10:52 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	200,405	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2404	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 10:52 am		
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: SSM HEALTHCARE SOUTHERN ILLINOIS		Contractor's Name: NATIONAL GOVT SERVICES		Contractor's Number: 06101				141.00	
142.00	Street: 1 GOOD SAMARITAN WAY		PO Box:						142.00	
143.00	City: MOUNT VERNON		State: IL		Zip Code: 62864				143.00	
									1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
									1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								N	146.00
									1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	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	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N			0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 10:52 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/15/2021
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/20/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 10:52 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.	KEN	JANOWSKI		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	480-206-6615	KEN.JANOWSKI@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 10:52 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE PRESIDENT		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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 10:52 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	20	7,300	32,147.00	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)		20	7,300	32,147.00	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)		20	7,300	32,147.00	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)		20				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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 10:52 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)	944	15	1,341			1.00
2.00	HMO and other (see instructions)	82	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	379	0	379			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	19			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,323	15	1,739			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,323	15	1,739	0.00	176.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						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)	5,244	0	20,351	0.00	36.95	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	213.31	27.00
28.00	Observation Bed Days		2	256			28.00
29.00	Ambulance Trips	985					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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 10:52 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	259	5	369	1.00
2.00 HMO and other (see instructions)			18	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	259	5	369	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: 14-1351 Component CCN: 14-3458		Period: From 03/01/2020 To 02/28/2021		Worksheet S-8 Date/Time Prepared: 7/28/2021 10:52 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				929 STACY BURK DRIVE				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				FLORA		IL 62839		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								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y		3		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				CLAY COUNTY HOSPITAL CLIN		143458		14.00
14.01					LOUISVILLE MEDICAL CLINIC		143487		14.01
14.02					CLAY CITY CLINIC		148558		14.02
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				CLAY				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		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1351

Period:

Worksheet S-8

Component CCN: 14-3458

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

Date/Time Prepared:

7/28/2021 10:52 am

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet S-10 Date/Time Prepared: 7/28/2021 10:52 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)			0.343784 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	553,357		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	11,834,521		6.00
7.00	Medicaid cost (line 1 times line 6)	4,068,519		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)	3,515,162		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	160,881		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	290,255		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,515,162		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	45,692	1,130,745	1,176,437 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,708	1,130,745	1,146,453 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	15,708	1,130,745	1,146,453 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,217,236		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	693,712		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,067,248		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,149,988		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	768,883		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,915,336		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,430,498		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet A Date/Time Prepared: 7/28/2021 10:52 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	274,490	274,490	56,103	330,593
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	6,391	6,391	136,056	142,447
2.00	00200	CAP REL COSTS-MVBLE EQUIP	877,954	877,954	8,246	886,200
3.00	00300	OTHER CAP REL COSTS	0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	182,912	2,383,820	133,644	2,700,376
5.01	00560	PURCHASING RECEIVING AND STORES	127,220	3,009	-13,748	116,481
5.02	00570	ADMITTING	73,445	182	222,910	296,537
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	530,064	253,212	-222,936	560,340
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	316,247	2,590,417	-200,683	2,705,981
7.00	00700	OPERATION OF PLANT	233,614	456,865	0	690,479
7.01	00701	RHC UTILITY EXPENSE	0	48,126	0	48,126
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,329	28,142	131,471
9.00	00900	HOUSEKEEPING	322,151	38,004	-14,395	345,760
10.00	01000	DIETARY	334,597	114,105	-287,361	161,341
11.00	01100	CAFETERIA	0	0	290,876	290,876
13.00	01300	NURSING ADMINISTRATION	684,808	36,561	0	721,369
14.00	01400	CENTRAL SERVICES & SUPPLY	35,178	10,140	0	45,318
15.00	01500	PHARMACY	202,282	99,021	0	301,303
16.00	01600	MEDICAL RECORDS & LIBRARY	379,656	95,574	-58	475,172
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,182,707	563,080	0	1,745,787
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	285,326	119,632	4,034	408,992
53.00	05300	ANESTHESIOLOGY	0	334,359	-4,359	330,000
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,994	674,295	-294	1,137,995
60.00	06000	LABORATORY	581,718	1,221,902	-150	1,803,470
65.00	06500	RESPIRATORY THERAPY	417,298	54,691	-83,724	388,265
66.00	06600	PHYSICAL THERAPY	520,204	25,669	-163	545,710
69.00	06900	ELECTROCARDIOLOGY	0	28,727	62,595	91,322
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	60,915	60,915
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	331,059	-14,175	316,884
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	14,175	14,175
73.00	07300	DRUGS CHARGED TO PATIENTS	90,929	529,040	-26	619,943
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	423,212	-589	422,623
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,959,152	252,376	-189,406	3,022,122
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0
90.00	09000	CLINIC	0	0	15,222	15,222
91.00	09100	EMERGENCY	669,696	1,039,957	-843	1,708,810
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	837,913	75,881	-1	913,793
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,431,111	13,065,080	7	24,496,198
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,541	8,133	-7	20,667
200.00		TOTAL (SUM OF LINES 118 through 199)	11,443,652	13,073,213	0	24,516,865

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1351

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

Worksheet A

Date/Time Prepared:
7/28/2021 10:52 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	68,841	399,434	1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	142,447	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	123,948	1,010,148	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,092,394	607,982	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	116,481	5.01
5.02	00570	ADMITTING	-367	296,170	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	560,340	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,228,601	4,934,582	5.04
7.00	00700	OPERATION OF PLANT	-6,803	683,676	7.00
7.01	00701	RHC UTILITY EXPENSE	0	48,126	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	131,471	8.00
9.00	00900	HOUSEKEEPING	0	345,760	9.00
10.00	01000	DIETARY	0	161,341	10.00
11.00	01100	CAFETERIA	-93,425	197,451	11.00
13.00	01300	NURSING ADMINISTRATION	-3,250	718,119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,318	14.00
15.00	01500	PHARMACY	-413	300,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,796	468,376	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-284,405	1,461,382	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	408,992	50.00
53.00	05300	ANESTHESIOLOGY	-330,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,137,995	54.00
60.00	06000	LABORATORY	0	1,803,470	60.00
65.00	06500	RESPIRATORY THERAPY	-2,045	386,220	65.00
66.00	06600	PHYSICAL THERAPY	0	545,710	66.00
69.00	06900	ELECTROCARDIOLOGY	-24,536	66,786	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,915	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	316,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,175	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	619,943	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	422,623	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-4,655	3,017,467	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	15,222	90.00
91.00	09100	EMERGENCY	0	1,708,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-4,000	909,793	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-431,699	24,064,499	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,667	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-431,699	24,085,166	200.00

RECLASSIFICATIONS

Provider CCN: 14-1351

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 10:52 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRICIATION					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	106,044		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	106,044		
	B - RESPIRATORY THERAPY					
1.00	ELECTROCARDIOLOGY	69.00	62,595	0		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	20,865	0		2.00
	TOTALS		83,460	0		
	C - INSURANCE EXPENSE					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	30,012		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,178		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	141,215		3.00
	TOTALS		0	200,405		
	D - OPERATING ROOM					
1.00	OPERATING ROOM	50.00	0	4,359		1.00
	TOTALS		0	4,359		
	E - RECLASS PORTION OF DIETARY TO CAFE					
1.00	CAFETERIA	11.00	216,906	73,970		1.00
	TOTALS		216,906	73,970		
	F - RECLASS IMPLANTABLE DEVICE COST					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,175		1.00
	TOTALS		0	14,175		
	G - DIEBETIES EDUCATION					
1.00	CLINIC	90.00	13,994	1,228		1.00
	TOTALS		13,994	1,228		
	H - SLEEP LAB PURCHASE SERVICE					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	40,050		1.00
	TOTALS		0	40,050		
	J - CONSOLIDATE DIETARY TRANSFERS					
1.00	DIETARY	10.00	0	3,515		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	3,515		
	K - REGISTRATION PERSONNEL					
1.00	ADMITTING	5.02	193,565	29,345		1.00
	TOTALS		193,565	29,345		
	L - LAUNDRY SALARIES					
1.00	LAUNDRY & LINEN SERVICE	8.00	26,306	1,836		1.00
2.00		0.00	0	0		2.00
	TOTALS		26,306	1,836		
	M - RHC PHYSICIAN BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	133,645		1.00
	TOTALS		0	133,645		
500.00	Grand Total: Increases		534,231	608,572		500.00

RECLASSIFICATIONS

Provider CCN: 14-1351

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 10:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRICIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,112	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,932	9		2.00
	TOTALS		0	106,044			
	B - RESPIRATORY THERAPY						
1.00	RESPIRATORY THERAPY	65.00	83,460	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		83,460	0			
	C - INSURANCE EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	200,405	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	200,405			
	D - OPERATING ROOM						
1.00	ANESTHESIOLOGY	53.00	0	4,359	0		1.00
	TOTALS		0	4,359			
	E - RECLASS PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	216,906	73,970	0		1.00
	TOTALS		216,906	73,970			
	F - RECLASS IMPLANTABLE DEVICE COST						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,175	0		1.00
	TOTALS		0	14,175			
	G - DIEBETIES EDUCATION						
1.00	RURAL HEALTH CLINIC	88.00	13,994	1,228	0		1.00
	TOTALS		13,994	1,228			
	H - SLEEP LAB PURCHASE SERVICE						
1.00	RURAL HEALTH CLINIC	88.00	0	40,050	0		1.00
	TOTALS		0	40,050			
	J - CONSOLIDATE DIETARY TRANSFERS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	26	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	278	0		3.00
4.00	HOUSEKEEPING	9.00	0	1	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	58	0		5.00
6.00	OPERATING ROOM	50.00	0	325	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	294	0		7.00
8.00	LABORATORY	60.00	0	150	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	264	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	163	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	26	0		11.00
12.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	589	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	489	0		13.00
14.00	EMERGENCY	91.00	0	843	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	1	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7	0		16.00
	TOTALS		0	3,515			
	K - REGISTRATION PERSONNEL						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	193,565	29,345	0		1.00
	TOTALS		193,565	29,345			
	L - LAUNDRY SALARIES						
1.00	PURCHASING RECEIVING AND STORES	5.01	13,431	317	0		1.00
2.00	HOUSEKEEPING	9.00	12,875	1,519	0		2.00
	TOTALS		26,306	1,836			
	M - RHC PHYSICIAN BENEFITS						
1.00	RURAL HEALTH CLINIC	88.00	0	133,645	0		1.00
	TOTALS		0	133,645			
500.00	Grand Total: Decreases		534,231	608,572			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 10:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	135,111	0	0	0	0	1.00	
2.00	Land Improvements	351,667	0	0	0	0	2.00	
3.00	Buildings and Fixtures	13,489,865	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	9,143,634	1,399,338	0	1,399,338	0	6.00	
7.00	HIT designated Assets	1,573,806	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	24,694,083	1,399,338	0	1,399,338	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	24,694,083	1,399,338	0	1,399,338	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	135,111	0					1.00
2.00	Land Improvements	351,667	0					2.00
3.00	Buildings and Fixtures	13,489,865	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	10,542,972	0					6.00
7.00	HIT designated Assets	1,573,806	0					7.00
8.00	Subtotal (sum of lines 1-7)	26,093,421	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	26,093,421	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 10:52 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	274,490	0	0	0	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0	6,391	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	648,944	229,010	0	0	0	2.00
3.00	Total (sum of lines 1-2)	923,434	229,010	0	0	6,391	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	274,490				1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	6,391				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	877,954				2.00
3.00	Total (sum of lines 1-2)	0	1,158,835				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 10:52 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	13,976,643	0	13,976,643	0.535639	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	12,116,778	0	12,116,778	0.464361	0	2.00
3.00	Total (sum of lines 1-2)	26,093,421	0	26,093,421	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	258,219	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	106,044	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	751,960	229,010	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,116,223	229,010	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	141,215	0	0	399,434	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	30,012	6,391	0	142,447	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	29,178	0	0	1,010,148	2.00
3.00	Total (sum of lines 1-2)	0	200,405	6,391	0	1,552,029	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1351

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RHC REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,085	CAFETERIA	11.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-5,715	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-3,300	RURAL HEALTH CLINIC	88.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-310,986			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-74	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,594,283			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-88,814	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-5,777	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	16.00
17.00	Sale of drugs to other than patients	B	-413	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,796	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,526	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RHC REL COSTS-BLDG & FIXT		0	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	26.01
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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1351

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	MISCELLANEOUS REVENUE	B	-16,425	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	PUBLIC RELATIONS	A	-54,926	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	LOBBYING EXPENSE	A	-8,779	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00	CRNA EXPENSE	A	-330,000	ANESTHESIOLOGY	53.00	0	37.00
38.00	EMPLOYEE BENEFITS LAB TESTS	A	-69,422	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	EMPLOYEE HEALTH INSURANCE REIMBURSEMENT	B	-348,851	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	FLORA CLINIC OTHER REVENUE	B	-605	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	AMBULANCE OTHER REVENUE	B	-4,000	AMBULANCE SERVICES	95.00	0	41.00
42.00	PENSION DIFFERENTIAL	A	-1,674,121	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	RMC MED DIRECTOR REIMBURSEMENT	B	-750	RURAL HEALTH CLINIC	88.00	0	43.00
44.00	REVENUE INTEGRITY OTHER REVENUE	B	-367	ADMITTING	5.02	0	44.00
45.00	MAINTENANCE OTHER REVENUE	B	-6,803	OPERATION OF PLANT	7.00	0	45.00
46.00	INFORMATION OTHER REVENUE	B	-81,120	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	46.00
47.00	CASH OVER	B	-77	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	47.00
48.00	PHYSICIAN FEE INCOME	B	-3,250	NURSING ADMINISTRATION	13.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-431,699				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1351

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 10:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	68,841	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	123,948	0	2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE OPERATING	2,962,714	561,220	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,155,503	561,220	5.00

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

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

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

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

6.00	G	SSM HEALTHCARE	1.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON FINANCIAL				100.00

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

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

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

Provider CCN: 14-1351

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 10:52 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	68,841	9		1.00
2.00	123,948	9		2.00
3.00	2,401,494	0		3.00
4.00	0	0		4.00
5.00	2,594,283			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1351

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 10:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. H	452,781	284,405	168,376	0	0	1.00
2.00	60.00	DR. L	25,043	0	25,043	0	0	2.00
3.00	65.00	DR. R	2,045	2,045	0	0	0	3.00
4.00	69.00	DR. K	19,326	19,326	0	0	0	4.00
5.00	69.00	DR. M	5,210	5,210	0	0	0	5.00
6.00	91.00	DR. E	998,356	0	998,356	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,502,761	310,986	1,191,775		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. H	0	0	0	0	0	1.00
2.00	60.00	DR. L	0	0	0	0	0	2.00
3.00	65.00	DR. R	0	0	0	0	0	3.00
4.00	69.00	DR. K	0	0	0	0	0	4.00
5.00	69.00	DR. M	0	0	0	0	0	5.00
6.00	91.00	DR. E	0	0	0	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. H	0	0	0	284,405		1.00
2.00	60.00	DR. L	0	0	0	0		2.00
3.00	65.00	DR. R	0	0	0	2,045		3.00
4.00	69.00	DR. K	0	0	0	19,326		4.00
5.00	69.00	DR. M	0	0	0	5,210		5.00
6.00	91.00	DR. E	0	0	0	0		6.00
7.00	0.00	AGGREGATE-	0	0	0	0		7.00
8.00	0.00	AGGREGATE-	0	0	0	0		8.00
9.00	0.00	AGGREGATE-	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	310,986		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	399,434	399,434			1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	142,447	0	142,447		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,010,148		1,010,148		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	607,982	0	0	607,982	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	116,481	9,069	0	23,049	5.01
5.02	00570	ADMITTING	296,170	3,144	0	7,990	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	560,340	0	3,599	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,934,582	194,712	10,385	494,886	5.04
7.00	00700	OPERATION OF PLANT	683,676	2,966	0	7,539	7.00
7.01	00701	RHC UTILITY EXPENSE	48,126	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	131,471	1,472	0	3,741	8.00
9.00	00900	HOUSEKEEPING	345,760	688	0	1,748	9.00
10.00	01000	DIETARY	161,341	6,916	0	17,578	10.00
11.00	01100	CAFETERIA	197,451	2,219	0	5,640	11.00
13.00	01300	NURSING ADMINISTRATION	718,119	1,857	3,599	4,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,318	3,225	0	8,197	14.00
15.00	01500	PHARMACY	300,890	3,107	0	7,896	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	468,376	0	13,984	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,461,382	45,181	0	114,833	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	408,992	30,084	0	76,461	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,137,995	22,221	0	56,477	54.00
60.00	06000	LABORATORY	1,803,470	8,862	0	22,523	60.00
65.00	06500	RESPIRATORY THERAPY	386,220	7,782	0	19,778	65.00
66.00	06600	PHYSICAL THERAPY	545,710	0	8,611	0	66.00
69.00	06900	ELECTROCARDIOLOGY	66,786	2,485	0	6,317	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60,915	2,478	2,925	6,298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	316,884	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,175	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	619,943	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,623	19,099	0	48,543	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,017,467	0	87,489	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	15,222	0	411	0	90.00
91.00	09100	EMERGENCY	1,708,810	20,675	0	52,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	909,793	9,202	0	23,388	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,064,499	397,444	131,003	1,010,148	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,990	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,667	0	11,444	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,085,166	399,434	142,447	1,010,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5A.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	155,273					5.01
5.02	00570	ADMITTING	158	323,122				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	274	0	583,949			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	11,790	0	0	5,664,903	5,664,903	5.04
7.00	00700	OPERATION OF PLANT	342	0	0	708,224	217,804	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	48,126	14,800	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	6,539	0	0	144,766	44,521	8.00
9.00	00900	HOUSEKEEPING	2,119	0	0	368,454	113,313	9.00
10.00	01000	DIETARY	2,440	0	0	195,178	60,024	10.00
11.00	01100	CAFETERIA	4,532	0	0	222,564	68,446	11.00
13.00	01300	NURSING ADMINISTRATION	570	0	0	769,028	236,504	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	375	0	0	59,178	18,199	14.00
15.00	01500	PHARMACY	6,843	0	0	330,600	101,671	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	234	0	0	504,861	155,263	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,846	87,316	36,165	1,816,089	558,513	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,388	18,920	40,069	593,648	182,568	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183	35,318	168,793	1,450,200	445,989	54.00
60.00	06000	LABORATORY	40,734	42,651	106,529	2,058,887	633,182	60.00
65.00	06500	RESPIRATORY THERAPY	2,868	18,873	7,724	462,825	142,335	65.00
66.00	06600	PHYSICAL THERAPY	254	8,643	24,470	618,198	190,118	66.00
69.00	06900	ELECTROCARDIOLOGY	262	1,894	11,503	92,918	28,576	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,217	77,057	23,698	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,666	45,017	22,338	404,905	124,523	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	783	213	497	15,668	4,818	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,933	59,394	39,423	766,026	235,581	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	39	0	10,275	500,579	153,946	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,263	0	25,927	3,253,416	1,000,552	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	11	0	112	16,577	5,098	90.00
91.00	09100	EMERGENCY	1,387	4,883	62,370	1,889,950	581,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,403	0	24,537	1,017,467	312,908	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,236	323,122	583,949	24,050,292	5,654,178	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,990	612	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37	0	0	32,884	10,113	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	155,273	323,122	583,949	24,085,166	5,664,903	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
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Cost Center Description			OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	926,028					7.00
7.01	00701	RHC UTILITY EXPENSE	0	62,926				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	7,192	0	196,479			8.00
9.00	00900	HOUSEKEEPING	3,361	0	0	485,128		9.00
10.00	01000	DIETARY	33,790	0	0	9,166	298,158	10.00
11.00	01100	CAFETERIA	10,842	0	0	2,941	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,071	1,861	0	9,322	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,757	0	0	4,274	0	14.00
15.00	01500	PHARMACY	15,178	0	0	4,117	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,232	0	26,663	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	220,736	0	196,479	59,875	261,846	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	146,978	0	0	39,868	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,562	0	0	29,447	0	54.00
60.00	06000	LABORATORY	43,295	0	0	11,744	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,018	0	0	10,312	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,453	0	16,420	0	66.00
69.00	06900	ELECTROCARDIOLOGY	12,143	0	0	3,294	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,107	1,513	0	8,862	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	93,311	0	0	25,311	36,312	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	45,245	0	166,822	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	213	0	784	0	90.00
91.00	09100	EMERGENCY	101,009	0	0	27,399	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	44,957	0	0	2,049	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	916,307	60,517	196,479	458,670	298,158	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,721	0	0	2,637	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,409	0	23,821	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	926,028	62,926	196,479	485,128	298,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	304,793					11.00
13.00	01300	NURSING ADMINISTRATION	27,322	1,053,108				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,403	0	98,811			14.00
15.00	01500	PHARMACY	8,070	0	0	459,636		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,147	0	0	0	709,166	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,186	605,253	0	0	422,465	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,384	116,117	0	0	39,442	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,512	0	0	0	8,829	54.00
60.00	06000	LABORATORY	23,209	0	0	0	22,672	60.00
65.00	06500	RESPIRATORY THERAPY	13,319	0	0	0	45,033	65.00
66.00	06600	PHYSICAL THERAPY	20,755	0	0	0	13,798	66.00
69.00	06900	ELECTROCARDIOLOGY	2,497	0	0	0	6,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	832	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	94,580	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,231	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,628	28,188	0	459,636	38,378	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	46,142	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	50,822	0	0	0	31,057	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	558	0	0	0	0	90.00
91.00	09100	EMERGENCY	26,719	267,012	0	0	27,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	33,430	31,983	0	0	7,143	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,793	1,048,553	98,811	459,636	709,166	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,555	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	304,793	1,053,108	98,811	459,636	709,166	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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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 RHC REL COSTS-BLDG & FIXT				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	RHC UTILITY EXPENSE				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,188,442	0	4,188,442	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,130,005	0	1,130,005	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,539	0	2,061,539	54.00
60.00	06000	LABORATORY	2,792,989	0	2,792,989	60.00
65.00	06500	RESPIRATORY THERAPY	711,842	0	711,842	65.00
66.00	06600	PHYSICAL THERAPY	863,742	0	863,742	66.00
69.00	06900	ELECTROCARDIOLOGY	145,994	0	145,994	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	124,069	0	124,069	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	624,008	0	624,008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,717	0	24,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,531,437	0	1,531,437	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	855,601	0	855,601	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,547,914	0	4,547,914	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	88.02
90.00	09000	CLINIC	23,230	0	23,230	90.00
91.00	09100	EMERGENCY	2,920,958	0	2,920,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,449,937	0	1,449,937	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,996,424	0	23,996,424	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,960	0	14,960	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,782	0	73,782	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,085,166	0	24,085,166	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	9,069	0	23,049	32,118
5.02	00570	ADMITTING	0	3,144	0	7,990	11,134
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	3,599	0	3,599
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	194,712	10,385	494,886	699,983
7.00	00700	OPERATION OF PLANT	0	2,966	0	7,539	10,505
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,472	0	3,741	5,213
9.00	00900	HOUSEKEEPING	0	688	0	1,748	2,436
10.00	01000	DIETARY	0	6,916	0	17,578	24,494
11.00	01100	CAFETERIA	0	2,219	0	5,640	7,859
13.00	01300	NURSING ADMINISTRATION	0	1,857	3,599	4,719	10,175
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,225	0	8,197	11,422
15.00	01500	PHARMACY	0	3,107	0	7,896	11,003
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13,984	0	13,984
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	45,181	0	114,833	160,014
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	30,084	0	76,461	106,545
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,221	0	56,477	78,698
60.00	06000	LABORATORY	0	8,862	0	22,523	31,385
65.00	06500	RESPIRATORY THERAPY	0	7,782	0	19,778	27,560
66.00	06600	PHYSICAL THERAPY	0	0	8,611	0	8,611
69.00	06900	ELECTROCARDIOLOGY	0	2,485	0	6,317	8,802
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,478	2,925	6,298	11,701
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	19,099	0	48,543	67,642
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	87,489	0	87,489
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0
90.00	09000	CLINIC	0	0	411	0	411
91.00	09100	EMERGENCY	0	20,675	0	52,547	73,222
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	9,202	0	23,388	32,590
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	397,444	131,003	1,010,148	1,538,595
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,990	0	0	1,990
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11,444	0	11,444
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	399,434	142,447	1,010,148	1,552,029

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	32,118				5.01
5.02	00570	ADMITTING	0	33	11,167			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	57	0	3,656		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	2,439	0	0	702,422	5.04
7.00	00700	OPERATION OF PLANT	0	71	0	0	27,007	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	1,835	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,353	0	0	5,520	8.00
9.00	00900	HOUSEKEEPING	0	438	0	0	14,050	9.00
10.00	01000	DIETARY	0	505	0	0	7,443	10.00
11.00	01100	CAFETERIA	0	937	0	0	8,487	11.00
13.00	01300	NURSING ADMINISTRATION	0	118	0	0	29,325	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78	0	0	2,257	14.00
15.00	01500	PHARMACY	0	1,415	0	0	12,607	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48	0	0	19,252	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	382	3,020	225	69,253	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	494	654	249	22,638	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	452	1,220	1,075	55,300	54.00
60.00	06000	LABORATORY	0	8,426	1,474	662	78,512	60.00
65.00	06500	RESPIRATORY THERAPY	0	593	652	48	17,649	65.00
66.00	06600	PHYSICAL THERAPY	0	52	299	152	23,574	66.00
69.00	06900	ELECTROCARDIOLOGY	0	54	65	71	3,543	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	20	2,938	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,275	1,555	139	15,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	162	7	3	597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,673	2,052	245	29,211	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8	0	64	19,089	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	468	0	161	124,065	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	2	0	1	632	90.00
91.00	09100	EMERGENCY	0	287	169	388	72,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	290	0	153	38,799	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	32,110	11,167	3,656	701,092	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	76	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8	0	0	1,254	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	32,118	11,167	3,656	702,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
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Cost Center Description			OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	37,583					7.00
7.01	00701	RHC UTILITY EXPENSE	0	1,835				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	292	0	12,378			8.00
9.00	00900	HOUSEKEEPING	136	0	0	17,060		9.00
10.00	01000	DIETARY	1,371	0	0	322	34,135	10.00
11.00	01100	CAFETERIA	440	0	0	103	0	11.00
13.00	01300	NURSING ADMINISTRATION	368	54	0	328	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	639	0	0	150	0	14.00
15.00	01500	PHARMACY	616	0	0	145	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	211	0	938	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,960	0	12,378	2,106	29,978	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,965	0	0	1,402	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,406	0	0	1,036	0	54.00
60.00	06000	LABORATORY	1,757	0	0	413	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,543	0	0	363	0	65.00
66.00	06600	PHYSICAL THERAPY	0	130	0	577	0	66.00
69.00	06900	ELECTROCARDIOLOGY	493	0	0	116	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	491	44	0	312	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,787	0	0	890	4,157	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,320	0	5,864	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	6	0	28	0	90.00
91.00	09100	EMERGENCY	4,099	0	0	964	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,825	0	0	72	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,188	1,765	12,378	16,129	34,135	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	395	0	0	93	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	70	0	838	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,583	1,835	12,378	17,060	34,135	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	17,826					11.00
13.00	01300	NURSING ADMINISTRATION	1,598	41,966				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82	0	14,628			14.00
15.00	01500	PHARMACY	472	0	0	26,258		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	886	0	0	0	35,319	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,759	24,120	0	0	21,040	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	666	4,627	0	0	1,964	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,082	0	0	0	440	54.00
60.00	06000	LABORATORY	1,357	0	0	0	1,129	60.00
65.00	06500	RESPIRATORY THERAPY	779	0	0	0	2,243	65.00
66.00	06600	PHYSICAL THERAPY	1,214	0	0	0	687	66.00
69.00	06900	ELECTROCARDIOLOGY	146	0	0	0	327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,002	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	626	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212	1,123	0	26,258	1,911	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	2,298	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,974	0	0	0	1,547	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	33	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,562	10,640	0	0	1,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,955	1,275	0	0	356	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,826	41,785	14,628	26,258	35,319	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,826	41,966	14,628	26,258	35,319	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet B
Part II
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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 RHC REL COSTS-BLDG & FIXT				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	RHC UTILITY EXPENSE				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	334,235	0	334,235	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	145,204	0	145,204	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	143,709	0	143,709	54.00
60.00	06000	LABORATORY	125,115	0	125,115	60.00
65.00	06500	RESPIRATORY THERAPY	51,430	0	51,430	65.00
66.00	06600	PHYSICAL THERAPY	35,296	0	35,296	66.00
69.00	06900	ELECTROCARDIOLOGY	13,617	0	13,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,555	0	15,555	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,411	0	35,411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,395	0	1,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,685	0	69,685	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,935	0	97,935	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	223,888	0	223,888	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	88.02
90.00	09000	CLINIC	1,113	0	1,113	90.00
91.00	09100	EMERGENCY	164,777	0	164,777	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	77,315	0	77,315	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,535,680	0	1,535,680	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,554	0	2,554	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,795	0	13,795	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,552,029	0	1,552,029	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1351

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	
			BLDG & FIXT (SQUARE FEET)	NEW CAP RHC REL COSTS-BLDG & FIXT (CLINIC SQ FT)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	53,999					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	27,708				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			53,730			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	10,366,248		4.00
5.01	00500	PURCHASING RECEIVING AND STORES	1,226	0	1,226	113,789	2,396,532	5.01
5.02	00570	ADMITTING	425	0	425	267,010	2,443	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	700	0	336,499	4,225	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	26,323	2,020	26,323	316,247	181,975	5.04
7.00	00700	OPERATION OF PLANT	401	0	401	233,614	5,286	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	199	0	199	26,306	100,930	8.00
9.00	00900	HOUSEKEEPING	93	0	93	309,276	32,702	9.00
10.00	01000	DIETARY	935	0	935	117,691	37,664	10.00
11.00	01100	CAFETERIA	300	0	300	216,906	69,948	11.00
13.00	01300	NURSING ADMINISTRATION	251	700	251	684,808	8,802	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	436	0	436	35,178	5,793	14.00
15.00	01500	PHARMACY	420	0	420	202,282	105,613	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,720	0	379,656	3,612	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,108	0	6,108	1,182,707	28,494	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,067	0	4,067	285,326	36,857	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004	0	3,004	463,994	33,693	54.00
60.00	06000	LABORATORY	1,198	0	1,198	581,718	628,693	60.00
65.00	06500	RESPIRATORY THERAPY	1,052	0	1,052	333,838	44,270	65.00
66.00	06600	PHYSICAL THERAPY	0	1,675	0	520,204	3,916	66.00
69.00	06900	ELECTROCARDIOLOGY	336	0	336	62,595	4,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	335	569	335	20,865	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	318,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	90,929	647,184	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582	0	2,582	0	598	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	17,018	0	2,050,666	34,926	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	80	0	13,994	171	90.00
91.00	09100	EMERGENCY	2,795	0	2,795	669,696	21,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,244	0	1,244	837,913	21,649	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,730	25,482	53,730	10,353,707	2,395,961	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,226	0	12,541	571	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	399,434	142,447	1,010,148	607,982	155,273	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.397063	5.141006	18.800447	0.058650	0.064791	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	32,118	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	0.013402	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: 14-1351

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			ADMITTING (INPATIENT CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.02	5.03	5A.04	5.04	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING	8,980,733					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	69,800,928				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-5,664,903	18,420,263		5.04
7.00	00700	OPERATION OF PLANT	0	0	0	708,224	25,624	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	48,126	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	144,766	199	8.00
9.00	00900	HOUSEKEEPING	0	0	0	368,454	93	9.00
10.00	01000	DIETARY	0	0	0	195,178	935	10.00
11.00	01100	CAFETERIA	0	0	0	222,564	300	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	769,028	251	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	59,178	436	14.00
15.00	01500	PHARMACY	0	0	0	330,600	420	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	504,861	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,426,727	4,322,912	0	1,816,089	6,108	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	525,853	4,789,460	0	593,648	4,067	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,641	20,176,766	0	1,450,200	3,004	54.00
60.00	06000	LABORATORY	1,185,445	12,733,575	0	2,058,887	1,198	60.00
65.00	06500	RESPIRATORY THERAPY	524,560	923,209	0	462,825	1,052	65.00
66.00	06600	PHYSICAL THERAPY	240,221	2,924,932	0	618,198	0	66.00
69.00	06900	ELECTROCARDIOLOGY	52,644	1,374,953	0	92,918	336	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	384,500	0	77,057	335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,251,205	2,670,043	0	404,905	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,914	59,387	0	15,668	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,801	4,712,342	0	766,026	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,228,217	0	500,579	2,582	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,099,065	0	3,253,416	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	13,428	0	16,577	0	90.00
91.00	09100	EMERGENCY	135,722	7,455,137	0	1,889,950	2,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,933,002	0	1,017,467	1,244	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,980,733	69,800,928	-5,664,903	18,385,389	25,355	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,990	269	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	32,884	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	323,122	583,949		5,664,903	926,028	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.035979	0.008366		0.307536	36.139088	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,167	3,656		702,422	37,583	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001243	0.000052		0.038133	1.466711	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: 14-1351

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		RHC UTILITY EXPENSE (CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAY)	CAFETERIA (GROSS SALARIES)	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	RHC UTILITY EXPENSE	23,668				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,435			8.00
9.00	00900	HOUSEKEEPING	0	0	49,489		9.00
10.00	01000	DIETARY	0	0	935	1,634	10.00
11.00	01100	CAFETERIA	0	0	300	0	11.00
13.00	01300	NURSING ADMINISTRATION	700	0	951	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	436	0	14.00
15.00	01500	PHARMACY	0	0	420	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,720	0	2,720	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,435	6,108	1,435	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	4,067	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,004	0	54.00
60.00	06000	LABORATORY	0	0	1,198	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,052	0	65.00
66.00	06600	PHYSICAL THERAPY	1,675	0	1,675	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	336	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	569	0	904	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	2,582	199	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,018	0	17,018	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	80	0	80	0	90.00
91.00	09100	EMERGENCY	0	0	2,795	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	209	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,762	1,435	46,790	1,634	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	269	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	906	0	2,430	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	62,926	196,479	485,128	298,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.658695	136.919164	9.802744	182.471236	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,835	12,378	17,060	34,135	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.077531	8.625784	0.344723	20.890453	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: 14-1351

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	RHC UTILITY EXPENSE					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	83,239				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	331,059			14.00
15.00	01500	PHARMACY	0	0	438,210		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	15,984	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,840	0	0	9,522	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,178	0	0	889	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	199	54.00
60.00	06000	LABORATORY	0	0	0	511	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,015	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	311	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	316,884	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,228	0	438,210	865	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,040	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	700	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	21,105	0	0	623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,528	0	0	161	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,879	331,059	438,210	15,984	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	360	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,053,108	98,811	459,636	709,166	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.651618	0.298469	1.048894	44.367242	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,966	14,628	26,258	35,319	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.504163	0.044185	0.059921	2.209647	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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,188,442		4,188,442	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,130,005		1,130,005	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,539		2,061,539	0	0	54.00	
60.00	06000	LABORATORY	2,792,989		2,792,989	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	711,842	0	711,842	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	863,742	0	863,742	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	145,994		145,994	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	124,069		124,069	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	624,008		624,008	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,717		24,717	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,531,437		1,531,437	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	855,601		855,601	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	4,547,914		4,547,914	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02	
90.00	09000	CLINIC	23,230		23,230	0	0	90.00	
91.00	09100	EMERGENCY	2,920,958		2,920,958	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	542,267		542,267		0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,449,937		1,449,937	0	0	95.00	
200.00		Subtotal (see instructions)	24,538,691	0	24,538,691	0	0	200.00	
201.00		Less Observation Beds	542,267		542,267		0	201.00	
202.00		Total (see instructions)	23,996,424	0	23,996,424	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,386,191		2,386,191		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	525,853	4,263,607	4,789,460	0.235936	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,641	19,195,125	20,176,766	0.102174	0.000000
60.00	06000	LABORATORY	1,185,445	11,548,130	12,733,575	0.219341	0.000000
65.00	06500	RESPIRATORY THERAPY	524,560	398,649	923,209	0.771052	0.000000
66.00	06600	PHYSICAL THERAPY	240,221	2,684,711	2,924,932	0.295303	0.000000
69.00	06900	ELECTROCARDIOLOGY	52,644	1,322,309	1,374,953	0.106181	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	384,500	384,500	0.322676	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,251,205	1,418,838	2,670,043	0.233707	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,914	53,473	59,387	0.416202	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,801	3,061,541	4,712,342	0.324984	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,228,217	1,228,217	0.696620	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,099,065	3,099,065		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	13,428	13,428	1.729967	0.000000
91.00	09100	EMERGENCY	135,722	7,319,415	7,455,137	0.391805	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,536	1,896,185	1,936,721	0.279992	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,933,002	2,933,002	0.494353	0.000000
200.00		Subtotal (see instructions)	8,980,733	60,820,195	69,800,928		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,980,733	60,820,195	69,800,928		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,386,191		2,386,191		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	525,853	4,263,607	4,789,460	0.235936	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,641	19,195,125	20,176,766	0.102174	0.000000
60.00	06000	LABORATORY	1,185,445	11,548,130	12,733,575	0.219341	0.000000
65.00	06500	RESPIRATORY THERAPY	524,560	398,649	923,209	0.771052	0.000000
66.00	06600	PHYSICAL THERAPY	240,221	2,684,711	2,924,932	0.295303	0.000000
69.00	06900	ELECTROCARDIOLOGY	52,644	1,322,309	1,374,953	0.106181	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	384,500	384,500	0.322676	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,251,205	1,418,838	2,670,043	0.233707	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,914	53,473	59,387	0.416202	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,801	3,061,541	4,712,342	0.324984	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,228,217	1,228,217	0.696620	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,099,065	3,099,065	1.467512	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	0	13,428	13,428	1.729967	0.000000
91.00	09100	EMERGENCY	135,722	7,319,415	7,455,137	0.391805	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,536	1,896,185	1,936,721	0.279992	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,933,002	2,933,002	0.494353	0.000000
200.00		Subtotal (see instructions)	8,980,733	60,820,195	69,800,928		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,980,733	60,820,195	69,800,928		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2021 10:52 am

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
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part II
Date/Time Prepared:
7/28/2021 10:52 am

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	145,204	4,789,460	0.030317	241,229	7,313	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	143,709	20,176,766	0.007122	366,133	2,608	54.00
60.00	06000 LABORATORY	125,115	12,733,575	0.009826	706,825	6,945	60.00
65.00	06500 RESPIRATORY THERAPY	51,430	923,209	0.055708	351,389	19,575	65.00
66.00	06600 PHYSICAL THERAPY	35,296	2,924,932	0.012067	66,827	806	66.00
69.00	06900 ELECTROCARDIOLOGY	13,617	1,374,953	0.009904	34,884	345	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,555	384,500	0.040455	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35,411	2,670,043	0.013262	736,957	9,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,395	59,387	0.023490	5,624	132	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,685	4,712,342	0.014788	1,085,160	16,047	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,935	1,228,217	0.079738	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	223,888	3,099,065	0.072244	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000 CLINIC	1,113	13,428	0.082887	0	0	90.00
91.00	09100 EMERGENCY	164,777	7,455,137	0.022102	2,984	66	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	43,272	1,936,721	0.022343	10,253	229	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,167,402	64,481,735		3,608,265	63,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet D Part IV Date/Time Prepared: 7/28/2021 10:52 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	4,789,460	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,176,766	0.000000
60.00	06000	LABORATORY	0	0	0	12,733,575	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	923,209	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,924,932	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,374,953	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	384,500	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,670,043	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,387	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,712,342	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,228,217	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,099,065	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000
90.00	09000	CLINIC	0	0	0	13,428	0.000000
91.00	09100	EMERGENCY	0	0	0	7,455,137	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,936,721	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	64,481,735	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 10:52 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	241,229	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	366,133	0	0	54.00
60.00	06000	LABORATORY	0.000000	706,825	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	351,389	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66,827	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	34,884	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	736,957	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,085,160	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,984	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	10,253	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		3,608,265	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2021 10:52 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	0.235936	0	1,840,516	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102174	0	8,048,602	0	0	54.00
60.00	06000	LABORATORY	0.219341	0	5,140,501	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.771052	0	177,410	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295303	0	864,463	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.106181	0	752,178	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.322676	0	162,000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233707	0	574,225	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416202	0	52,836	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324984	0	1,302,171	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.696620	0	1,203,215	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	1.729967	0	8,309	0	0	90.00
91.00	09100	EMERGENCY	0.391805	0	2,658,600	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279992	0	1,037,219	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.494353		0			95.00
200.00		Subtotal (see instructions)		0	23,822,245	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	23,822,245	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2021 10:52 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	434,244	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	822,358	0	54.00	
60.00	06000	LABORATORY	1,127,523	0	60.00	
65.00	06500	RESPIRATORY THERAPY	136,792	0	65.00	
66.00	06600	PHYSICAL THERAPY	255,279	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	79,867	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	52,274	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	134,200	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,990	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	423,185	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	838,184	0	76.00	
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00	
88.01	08801	RURAL HEALTH CLINIC II			88.01	
88.02	08802	RURAL HEALTH CLINIC III			88.02	
90.00	09000	CLINIC	14,374	0	90.00	
91.00	09100	EMERGENCY	1,041,653	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	290,413	0	92.00	
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00	
200.00		Subtotal (see instructions)	5,672,336	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	5,672,336	0	202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part I
Date/Time Prepared:
7/28/2021 10:52 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	334,235	64,289	269,946	1,597	169.03	30.00
200.00	Total (lines 30 through 199)	334,235		269,946	1,597		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	15	2,535				30.00
200.00	Total (lines 30 through 199)	15	2,535				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part II
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	145,204	4,789,460	0.030317	14,255	432	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	143,709	20,176,766	0.007122	28,825	205	54.00
60.00	06000 LABORATORY	125,115	12,733,575	0.009826	15,060	148	60.00
65.00	06500 RESPIRATORY THERAPY	51,430	923,209	0.055708	2,214	123	65.00
66.00	06600 PHYSICAL THERAPY	35,296	2,924,932	0.012067	476	6	66.00
69.00	06900 ELECTROCARDIOLOGY	13,617	1,374,953	0.009904	640	6	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,555	384,500	0.040455	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35,411	2,670,043	0.013262	3,011	40	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,395	59,387	0.023490	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,685	4,712,342	0.014788	16,120	238	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,935	1,228,217	0.079738	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	223,888	3,099,065	0.072244	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000 CLINIC	1,113	13,428	0.082887	0	0	90.00
91.00	09100 EMERGENCY	164,777	7,455,137	0.022102	4,708	104	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	43,272	1,936,721	0.022343	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,167,402	64,481,735		85,309	1,302	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet D Part III Date/Time Prepared: 7/28/2021 10:52 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,597	0.00	15	30.00			
200.00		Total (lines 30 through 199)	0	0	1,597		15	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1351		Period: From 03/01/2020 To 02/28/2021		Worksheet D Part IV Date/Time Prepared: 7/28/2021 10:52 am	
			Title XIX		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			Title XIX		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	4,789,460	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,176,766	0.000000
60.00	06000	LABORATORY	0	0	0	12,733,575	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	923,209	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,924,932	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,374,953	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	384,500	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,670,043	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,387	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,712,342	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,228,217	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,099,065	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000
90.00	09000	CLINIC	0	0	0	13,428	0.000000
91.00	09100	EMERGENCY	0	0	0	7,455,137	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,936,721	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	64,481,735	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description			Title XIX		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	14,255	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,825	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	15,060	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,214	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	476	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	640	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,011	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,120	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,708	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		85,309	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2021 10:52 am

			Title XIX		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	0.235936	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102174	0	0	0	0	54.00
60.00	06000	LABORATORY	0.219341	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.771052	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295303	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.106181	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.322676	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233707	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416202	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324984	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.696620	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	1.729967	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.391805	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279992	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.494353	0	0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2021 10:52 am

			Title XIX		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	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet D-1 Date/Time Prepared: 7/28/2021 10:52 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,995	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,597	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,341	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		233	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)		146	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		17	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)		944	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)		233	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)		146	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		147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.42	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,188,442	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)		2,508	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)		311	25.00
26.00	Total swing-bed cost (see instructions)		805,628	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,382,814	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,382,814	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)		2,118.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,999,609	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,999,609	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,075,010	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,074,619	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					493,548	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					309,262	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					802,810	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					256	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,118.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					542,267	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 10:52 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	334,235	4,188,442	0.079799	542,267	43,272
91.00	Nursing School cost	0	4,188,442	0.000000	542,267	0
92.00	Allied health cost	0	4,188,442	0.000000	542,267	0
93.00	All other Medical Education	0	4,188,442	0.000000	542,267	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet D-1 Date/Time Prepared: 7/28/2021 10:52 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,995 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,597 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,341 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			233 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)			146 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			17 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)			15 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			147.50 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.42 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,188,442 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)			2,508 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)			311 25.00
26.00	Total swing-bed cost (see instructions)			805,628 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,382,814 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,382,814 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)			2,118.23 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			31,773 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)			31,773 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					19,315	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					51,088	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					256	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,118.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					542,267	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 10:52 am

		Title XIX		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	334,235	4,188,442	0.079799	542,267	43,272	90.00
91.00 Nursing School cost	0	4,188,442	0.000000	542,267	0	91.00
92.00 Allied health cost	0	4,188,442	0.000000	542,267	0	92.00
93.00 All other Medical Education	0	4,188,442	0.000000	542,267	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet D-3 Date/Time Prepared: 7/28/2021 10:52 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,211,700		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235936	241,229	56,915	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102174	366,133	37,409	54.00
60.00	06000 LABORATORY	0.219341	706,825	155,036	60.00
65.00	06500 RESPIRATORY THERAPY	0.771052	351,389	270,939	65.00
66.00	06600 PHYSICAL THERAPY	0.295303	66,827	19,734	66.00
69.00	06900 ELECTROCARDIOLOGY	0.106181	34,884	3,704	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.322676	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.233707	736,957	172,232	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416202	5,624	2,341	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.324984	1,085,160	352,660	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.696620	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.729967	0	0	90.00
91.00	09100 EMERGENCY	0.391805	2,984	1,169	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.279992	10,253	2,871	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,608,265	1,075,010	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)		3,608,265		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351 Component CCN: 14-Z351	Period: From 03/01/2020 To 02/28/2021	Worksheet D-3 Date/Time Prepared: 7/28/2021 10:52 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235936	1,554	367	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102174	10,027	1,024	54.00
60.00	06000 LABORATORY	0.219341	123,971	27,192	60.00
65.00	06500 RESPIRATORY THERAPY	0.771052	77,206	59,530	65.00
66.00	06600 PHYSICAL THERAPY	0.295303	148,337	43,804	66.00
69.00	06900 ELECTROCARDIOLOGY	0.106181	640	68	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.322676	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.233707	120,144	28,078	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416202	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.324984	191,888	62,361	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.696620	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.729967	0	0	90.00
91.00	09100 EMERGENCY	0.391805	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.279992	314	88	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		674,081	222,512	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)		674,081		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet D-3 Date/Time Prepared: 7/28/2021 10:52 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		20,100		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235936	14,255	3,363	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102174	28,825	2,945	54.00
60.00	06000 LABORATORY	0.219341	15,060	3,303	60.00
65.00	06500 RESPIRATORY THERAPY	0.771052	2,214	1,707	65.00
66.00	06600 PHYSICAL THERAPY	0.295303	476	141	66.00
69.00	06900 ELECTROCARDIOLOGY	0.106181	640	68	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.322676	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.233707	3,011	704	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416202	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.324984	16,120	5,239	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.696620	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.467512	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000 CLINIC	1.729967	0	0	90.00
91.00	09100 EMERGENCY	0.391805	4,708	1,845	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.279992	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		85,309	19,315	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)		85,309		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet E Part B Date/Time Prepared: 7/28/2021 10:52 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,672,336	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,672,336	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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		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)		5,729,059	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)		31,899	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,717,937	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,979,223	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,979,223	30.00
31.00	Primary payer payments		895	31.00
32.00	Subtotal (line 30 minus line 31)		1,978,328	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)		867,924	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		564,151	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		634,333	36.00
37.00	Subtotal (see instructions)		2,542,479	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	ILLING ADJUSTMENT		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)		2,542,479	40.00
40.01	Sequestration adjustment (see instructions)		8,390	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,466,316	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)		67,773	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: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 10:52 am

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,852,971		2,541,947	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	01/06/2021	183,364		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	01/06/2021	75,631	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)		183,364		-75,631	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,036,335		2,466,316	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		893,554		67,773	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,929,889		2,534,089	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: 14-1351

Period:

Worksheet E-1

Component CCN: 14-Z351

From 03/01/2020
To 02/28/2021Part I
Date/Time Prepared:
7/28/2021 10:52 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		744,033		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	01/06/2021	111,825		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)		111,825		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)		855,858		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		172,265		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,028,123		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: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 10:52 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: 14-1351
 Component CCN: 14-Z351

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

 Worksheet E-2
 Date/Time Prepared:
 7/28/2021 10:52 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)		810,838	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		224,737	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		379	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)		1,035,575	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,035,575	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)		1,035,575	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		4,048	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,031,527	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)		1,031,527	0	19.00
19.01	Sequestration adjustment (see instructions)		3,404	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		855,858	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)		172,265	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet E-3 Part V Date/Time Prepared: 7/28/2021 10:52 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,074,619	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,074,619	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,105,365	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,105,365	19.00
20.00	Deductibles (exclude professional component)		242,668	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,862,697	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,862,697	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		118,297	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		76,893	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		103,089	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,939,590	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)		2,939,590	30.00
30.01	Sequestration adjustment (see instructions)		9,701	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,036,335	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		893,554	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1351	Period: From 03/01/2020 To 02/28/2021	Worksheet E-3 Part VII Date/Time Prepared: 7/28/2021 10:52 am
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	51,088		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	51,088	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	51,088	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	85,309	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	85,309	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	85,309	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	34,221	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	51,088	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	51,088	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	51,088	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	51,088	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	51,088	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	51,088	0	40.00
41.00	Interim payments	20,386	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	30,702	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1351

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

Worksheet G

Date/Time Prepared:

7/28/2021 10:52 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	6,932,216	0	0	0	1.00
2.00	Temporary investments	16,836,007	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,485,349	0	0	0	4.00
5.00	Other receivable	190,499	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,088,136	0	0	0	6.00
7.00	Inventory	193,606	0	0	0	7.00
8.00	Prepaid expenses	180,964	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,730,505	0	0	0	11.00
FIXED ASSETS						
12.00	Land	135,111	0	0	0	12.00
13.00	Land improvements	351,667	0	0	0	13.00
14.00	Accumulated depreciation	-351,667	0	0	0	14.00
15.00	Buildings	13,489,865	0	0	0	15.00
16.00	Accumulated depreciation	-11,569,964	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	10,542,972	0	0	0	19.00
20.00	Accumulated depreciation	-8,100,404	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	1,573,806	0	0	0	27.00
28.00	Accumulated depreciation	-1,550,827	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,813	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,523,372	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,457,264	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	2,614,606	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,071,870	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,325,747	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,284,215	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,228,983	0	0	0	38.00
39.00	Payroll taxes payable	71,069	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,772,455	0	0	0	40.00
41.00	Deferred income	4,003,117	0	0	0	41.00
42.00	Accelerated payments	4,791,879	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	186,128	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,337,846	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,078,550	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,078,550	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,416,396	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,909,351	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)	18,909,351	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,325,747	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1351

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

Worksheet G-1

Date/Time Prepared:
7/28/2021 10:52 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		13,504,681		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,404,670				2.00
3.00	Total (sum of line 1 and line 2)		18,909,351		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)		18,909,351		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,909,351		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2020
To 02/28/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 10:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,848,940		2,848,940	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	498,979		498,979	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)	3,347,919		3,347,919	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,347,919		3,347,919	17.00
18.00	Ancillary services	5,624,596	53,137,648	58,762,244	18.00
19.00	Outpatient services	0	2,291,553	2,291,553	19.00
20.00	RURAL HEALTH CLINIC	0	2,848,940	2,848,940	20.00
20.01	RURAL HEALTH CLINIC II	0	498,979	498,979	20.01
20.02	RURAL HEALTH CLINIC III	0	1,067,986	1,067,986	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	3,173,894	3,173,894	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY) CLINIC DIABETES EDUC	0	13,032	13,032	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,972,515	63,032,032	72,004,547	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,516,865		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,516,865		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1351

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

Worksheet G-3

Date/Time Prepared:
7/28/2021 10:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,004,547	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,689,487	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,315,060	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,516,865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,798,195	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	636,843	6.00
7.00	Income from investments	73,915	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	411	10.00
11.00	Rebates and refunds of expenses	5,715	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	88,814	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	5,777	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	6,796	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	2,150	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	3,526	21.00
22.00	Rental of hospital space	59,988	22.00
23.00	Governmental appropriations	241,100	23.00
24.00	FLORA CLINIC OTHER REVENUE	607	24.00
24.01	REINSURANCE REFUNDS	348,851	24.01
24.02	MISCELLANEOUS INCOME	16,425	24.02
24.03	GRANT INCOME	84,937	24.03
24.04	EMERGENCY GRANT REVENUE	3,271	24.04
24.05	NET 340B PROGRAM REVENUE	522,942	24.05
24.06	SALE OF EQUIPMENT	2,500	24.06
24.07	AMBULANCE OTHER REVENUE	4,000	24.07
24.08	RURAL HEALTH CLINIC GRANT REVENUE	27,500	24.08
24.09	REVENUE INTEGRITY REVENUE	367	24.09
24.10	MAINTENANCE OTHER REVENUE	6,803	24.10
24.11	PUBLIC RELATION OTHER REVENUE	5,760	24.11
24.12	DATA PROCESSING REVENUE	81,120	24.12
24.13	CASH OVER	77	24.13
24.14	PHYSICIAN FEE REVENUE	3,250	24.14
24.15	SALE OF SCRAP	74	24.15
24.16	RHC MEDICAL DIRECTOR REIMBURSEMENT	750	24.16
24.50	COVID-19 PHE Funding	1,372,206	24.50
25.00	Total other income (sum of lines 6-24)	3,606,475	25.00
26.00	Total (line 5 plus line 25)	5,404,670	26.00
27.00	GAIN/(LOSS) ON DISPOSAL	0	27.00
27.01	LOSS ON INVESTMENTS	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,404,670	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351

Period:

Worksheet M-1

Component CCN: 14-3458

From 03/01/2020
To 02/28/2021Date/Time Prepared:
7/28/2021 10:52 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	920,320	0	920,320	-281,755	638,565 1.00
2.00	Physician Assistant	138,734	0	138,734	-1,094	137,640 2.00
3.00	Nurse Practitioner	644,211	0	644,211	-117,266	526,945 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	627,831	0	627,831	0	627,831 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	628,056	0	628,056	-13,994	614,062 9.00
10.00	Subtotal (sum of lines 1 through 9)	2,959,152	0	2,959,152	-414,109	2,545,043 10.00
11.00	Physician Services Under Agreement	0	66,050	66,050	-40,050	26,000 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	120,110	120,110	0	120,110 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	186,160	186,160	-40,050	146,110 14.00
15.00	Medical Supplies	0	35,097	35,097	-489	34,608 15.00
16.00	Transportation (Health Care Staff)	0	4,297	4,297	0	4,297 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	16,772	16,772	-1,228	15,544 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,166	56,166	-1,717	54,449 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,959,152	242,326	3,201,478	-455,876	2,745,602 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	266,470	266,470 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	266,470	266,470 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	8,160	8,160	0	8,160 29.00
30.00	Administrative Costs	0	1,890	1,890	0	1,890 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	10,050	10,050	0	10,050 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,959,152	252,376	3,211,528	-189,406	3,022,122 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351

Period:

Worksheet M-1

Component CCN: 14-3458

From 03/01/2020
To 02/28/2021Date/Time Prepared:
7/28/2021 10:52 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	-750	637,815	1.00
2.00	Physician Assistant	0	137,640	2.00
3.00	Nurse Practitioner	0	526,945	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	627,831	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	614,062	9.00
10.00	Subtotal (sum of lines 1 through 9)	-750	2,544,293	10.00
11.00	Physician Services Under Agreement	0	26,000	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	120,110	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	146,110	14.00
15.00	Medical Supplies	0	34,608	15.00
16.00	Transportation (Health Care Staff)	0	4,297	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	-605	14,939	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-605	53,844	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,355	2,744,247	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	266,470	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	266,470	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-3,300	4,860	29.00
30.00	Administrative Costs	0	1,890	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,300	6,750	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,655	3,017,467	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1351

Period:

Worksheet M-2

Component CCN: 14-3458

From 03/01/2020
To 02/28/2021Date/Time Prepared:
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				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	1.33	6,639	4,200	5,586		1.00
2.00	Physician Assistant	0.40	1,864	2,100	840		2.00
3.00	Nurse Practitioner	1.93	11,807	2,100	4,053		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.66	20,310		10,479	20,310	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.01	41			41	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.67	20,351			20,351	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)					2,744,247	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					266,470	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,010,717	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.911493	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					6,750	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,530,447	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,537,197	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,537,197	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,401,144	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,145,391	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2020 To 02/28/2021	Worksheet M-3 Date/Time Prepared: 7/28/2021 10:52 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)			4,145,391	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			14,356	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,131,035	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,351	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)			20,351	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.99	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			202.99	202.99	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,567	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	927,055	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	677	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	137,424	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	137,424	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	1,064,479	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			1,018,997	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			54,091	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			56,506	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.)			744,178	16.04	
16.05	Total program cost (see instructions)		0	800,684	16.05	
17.00	Primary payer amounts			265	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			77,751	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			177,372	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			800,419	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			8,728	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			809,147	22.00	
23.00	Allowable bad debts (see instructions)			81,027	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			52,668	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			67,275	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)			861,815	26.00	
26.01	Sequestration adjustment (see instructions)			2,844	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			1,002,704	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)			-143,733	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: 14-1351 Component CCN: 14-3458	Period: From 03/01/2020 To 02/28/2021	Worksheet M-4 Date/Time Prepared: 7/28/2021 10:52 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,544,293	2,544,293	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000131	0.000838	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		333	2,132	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,471	3,568	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,804	5,700	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,744,247	2,744,247	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,401,144	1,401,144	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001386	0.002077	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,942	2,910	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		5,746	8,610	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		35	223	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		164.17	38.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		32	90	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		5,253	3,475	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)			14,356	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)			8,728	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2020 To 02/28/2021	Worksheet M-5 Date/Time Prepared: 7/28/2021 10:52 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,081,513	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		01/06/2021	78,809	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)		-78,809	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,002,704	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		143,733	6.02	
7.00	Total Medicare program liability (see instructions)		858,971	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00