

State Copy

Health Financial Systems

GRAHAM HOSPITAL ASSOCIATION

In Lieu of Form CMS-2552-10

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/16/2020 2:07 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	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 GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-425,797	74,638	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	736,319	-658		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		522,769		0	10.00
10.01	ELMWOOD RHC II	0		805		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	310,522	597,554	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 210 WEST WALNUT			PO Box:				1.00		
2.00	City: CANTON			State: IL		Zip Code: 61520-		County: FULTON		
		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		GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N
10.00	Hospital-Based NF		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O
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		GRAHAM MEDICAL GROUP - LEWISTOWN	143493	99914		01/01/2008	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		GRAHAM MEDICAL GROUP - ELMWOOD	148603	99914		10/23/2019	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,286	0	0	0	162	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		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.					1		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.					07/01/2019	06/30/2020	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			0	0	1,075,926	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.			Y		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			Y		5.00	122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y		05/26/2020		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.			Y		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/16/2020 2:07 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/16/2020 2:07 pm	
			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	09/17/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N 1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
		Part A		Part B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/30/2020	Y	07/30/2020
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: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	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.		Y		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.		N		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.	PAUL	TRACZEK		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715.858.6619	PTRACZEK@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/16/2020 2:07 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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

HFS Supplemental Information

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part IX
Date/Time Prepared:
11/16/2020 2:07 pm

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State 1.00		
STATE MEDICAID FORMS				
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,908	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,908	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,830	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		43	15,738	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,320		0	19.00
20.00 NURSING FACILITY	45.00	18	6,588		0	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
26.01 ELMWOOD RHC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		81				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: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,171	871	5,869		1.00
2.00	HMO and other (see instructions)	860	162			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	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,171	871	5,869		7.00
8.00	INTENSIVE CARE UNIT	371	174	973		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		241	415		13.00
14.00	Total (see instructions)	3,542	1,286	7,257	0.00	453.93
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	1,912	139	2,952	0.00	14.79
20.00	NURSING FACILITY		3,162	5,213	0.00	14.42
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)	17,461	25,044	89,977	0.00	78.74
26.01	ELMWOOD RHC	0	0	2,633	0.00	6.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	567.88
28.00	Observation Bed Days		0	1,722		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			102		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: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	907	341	1,919	1.00
2.00 HMO and other (see instructions)			219	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	907	341	1,919	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	0.00					19.00
20.00 NURSING FACILITY	0.00					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
26.01 ELMWOOD RHC	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	32,906,169	0	32,906,169	1,181,181.24	27.86 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		1,553,030	0	1,553,030	12,646.40	122.80 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		4,538,034	-21,215	4,516,819	26,658.18	169.43 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,333,777	0	3,333,777	142,702.33	23.36 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	837,130	0	837,130	30,763.20	27.21 9.00
10.00	Excluded area salaries (see instructions)		1,805,454	73,988	1,879,442	75,993.16	24.73 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,477,474	0	1,477,474	26,296.84	56.18 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,412,205	0	4,412,205		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		688,909	0	688,909		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		569,159	0	569,159		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,655,336	0	1,655,336		
24.00	Wage-related costs (RHC/FQHC)		1,784,164	0	1,784,164		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	160,441	0	160,441	8,525.34	18.82	26.00
27.00	Administrative & General	5.00	6,134,912	0	6,134,912	244,691.20	25.07	27.00
28.00	Administrative & General under contract (see inst.)		1,149,763	0	1,149,763	12,598.39	91.26	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	813,982	-18	813,964	47,292.70	17.21	30.00
31.00	Laundry & Linen Service	8.00	26,811	0	26,811	2,329.60	11.51	31.00
32.00	Housekeeping	9.00	875,571	0	875,571	68,931.20	12.70	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	706,689	-417,795	288,894	19,042.09	15.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	417,795	417,795	28,132.31	14.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	662,242	0	662,242	20,009.60	33.10	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	776,389	0	776,389	25,126.40	30.90	40.00
41.00	Medical Records & Medical Records Library	16.00	400,488	0	400,488	36,545.60	10.96	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/16/2020 2:07 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	24,631,091	21,215	24,652,306	1,011,772.72	24.37	1.00
2.00	Excluded area salaries (see instructions)	2,642,584	73,988	2,716,572	106,756.36	25.45	2.00
3.00	Subtotal salaries (line 1 minus line 2)	21,988,507	-52,773	21,935,734	905,016.36	24.24	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,477,474	0	1,477,474	26,296.84	56.18	4.00
5.00	Subtotal wage-related costs (see inst.)	4,412,205	0	4,412,205	0.00	20.11	5.00
6.00	Total (sum of lines 3 thru 5)	27,878,186	-52,773	27,825,413	931,313.20	29.88	6.00
7.00	Total overhead cost (see instructions)	11,707,288	-18	11,707,270	513,224.43	22.81	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	721,298	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	7,500	6.00
7.00	Employee Managed Care Program Administration Fees	291,670	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,895,923	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,173	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	139,560	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	256,075	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,253,233	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	125,365	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	260,187	21.00
22.00	Day Care Cost and Allowances	14,276	22.00
23.00	Tuition Reimbursement	110,513	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,109,773	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,712,931	9,109,773	1.00
2.00	Hospital	1,477,474	9,109,773	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	235,457	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-3493		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/16/2020 2:07 pm		
				RHC I		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				180 S MAIN STREET			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				CANTON IL 61520			2.00		
								1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)								4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00	
7.00	Appalachian Regional Commission								7.00	
8.00	Look-Alikes								8.00	
9.00	OTHER (SPECIFY)								9.00	
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from to		from to		from		
				1.00 2.00		3.00 4.00		5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:30	15:00	07:30	17:30	07:30	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		4		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number				FARMINGTON CLINIC		143494		14.00	
14.01					CANTON CLINIC		143492		14.01	
14.02					LEWISTOWN CLINIC		143493		14.02	
14.03									14.03	
				Y/N		V		XVIII		
				1.00		2.00		3.00		
								XIX		
								Total Visits		
								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				FULTON			2.00		

MCRIF32 - 16.4.169.4

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-8603		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/16/2020 2:07 pm		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				1024 N MAGNOLIA STREET				1.00	
				City	State	ZIP Code				
				1.00	2.00	3.00				
2.00	City, State, ZIP Code, County				ELMWOOD		IL 61529		2.00	
						1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)								4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00	
7.00	Appalachian Regional Commission								7.00	
8.00	Look-Alikes								8.00	
9.00	OTHER (SPECIFY)								9.00	
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from	to	from	to	from		
				1.00	2.00	3.00	4.00	5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:30	15:00	07:30	17:30	07:30	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.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N	V	XVIII	XIX	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				PEORIA				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				17:30	07:30	17:30	07:30	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-0001 Component CCN:14-8603		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/16/2020 2:07 pm	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:30	17:30	08:30	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/16/2020 2:07 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.359591 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,916,176		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,571,695		5.00
6.00	Medicaid charges	45,621,439		6.00
7.00	Medicaid cost (line 1 times line 6)	16,405,059		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	6,917,188		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,917,188		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)	2,484,840	1,627,265	4,112,105 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	893,526	1,627,265	2,520,791 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)	893,526	1,627,265	2,520,791 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)	4,307,514		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	387,228		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	595,736		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,711,778		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,543,230		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,064,021		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,981,209		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,659,626	7,659,626	-2,873,755	4,785,871	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,876,803	2,876,803	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	160,441	9,470,743	9,631,184	-115,951	9,515,233	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,134,912	8,546,407	14,681,319	-107,015	14,574,304	5.00
7.00	00700	OPERATION OF PLANT	813,982	2,098,840	2,912,822	-18	2,912,804	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,811	205,703	232,514	0	232,514	8.00
9.00	00900	HOUSEKEEPING	875,571	174,515	1,050,086	0	1,050,086	9.00
10.00	01000	DIETARY	706,689	580,825	1,287,514	-771,330	516,184	10.00
11.00	01100	CAFETERIA	0	0	0	771,330	771,330	11.00
13.00	01300	NURSING ADMINISTRATION	662,242	326,838	989,080	0	989,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	776,389	1,650,821	2,427,210	0	2,427,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	400,488	252,057	652,545	0	652,545	16.00
20.00	02000	NURSING SCHOOL	1,124,071	236,618	1,360,689	0	1,360,689	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,363,824	680,295	4,044,119	86,351	4,130,470	30.00
31.00	03100	INTENSIVE CARE UNIT	681,158	39,256	720,414	-2,945	717,469	31.00
43.00	04300	NURSERY	0	22,661	22,661	8,849	31,510	43.00
44.00	04400	SKILLED NURSING FACILITY	837,130	95,169	932,299	-66	932,233	44.00
45.00	04500	NURSING FACILITY	633,902	35,579	669,481	0	669,481	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,505,480	3,172,570	4,678,050	-2,413,708	2,264,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	15,535	15,535	52.01
53.00	05300	ANESTHESIOLOGY	1,553,030	57,205	1,610,235	0	1,610,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	816,550	871,955	1,688,505	-1,652	1,686,853	54.00
57.00	05700	CT SCAN	67,048	201,331	268,379	0	268,379	57.00
58.00	05800	MRI	63,295	116,786	180,081	0	180,081	58.00
60.00	06000	LABORATORY	1,495,205	2,014,953	3,510,158	0	3,510,158	60.00
65.00	06500	RESPIRATORY THERAPY	608,942	95,504	704,446	0	704,446	65.00
66.00	06600	PHYSICAL THERAPY	33,857	1,771,846	1,805,703	0	1,805,703	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	792,278	792,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,693,833	1,693,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,367,983	2,367,983	0	2,367,983	73.00
76.97	07697	CARDIAC REHABILITATION	145,089	85,225	230,314	18,905	249,219	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,120,933	10,895,946	16,016,879	-810,490	15,206,389	88.00
88.01	08801	ELMWOOD RHC	0	0	0	512,039	512,039	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	614,654	787,720	1,402,374	11,452	1,413,826	90.01
91.00	09100	EMERGENCY	3,247,736	260,040	3,507,776	55,318	3,563,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	389,259	793,756	1,183,015	13,985	1,197,000	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,858,688	55,568,773	88,427,461	-240,252	88,187,209	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	733	733	18	751	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	3,971	3,971	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	47,481	22,207	69,688	0	69,688	194.11
194.12	07962	ELMWOOD CLINIC	0	0	0	236,263	236,263	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	32,906,169	55,591,713	88,497,882	0	88,497,882	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-679,098	4,106,773	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,835	2,872,968	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-760,998	8,754,235	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,373,972	11,200,332	5.00
7.00	00700	OPERATION OF PLANT	0	2,912,804	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	232,514	8.00
9.00	00900	HOUSEKEEPING	-3,120	1,046,966	9.00
10.00	01000	DIETARY	-299,800	216,384	10.00
11.00	01100	CAFETERIA	-278,035	493,295	11.00
13.00	01300	NURSING ADMINISTRATION	-3,716	985,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,703,808	723,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,751	625,794	16.00
20.00	02000	NURSING SCHOOL	-248,076	1,112,613	20.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-135,079	3,995,391	30.00
31.00	03100	INTENSIVE CARE UNIT	0	717,469	31.00
43.00	04300	NURSERY	0	31,510	43.00
44.00	04400	SKILLED NURSING FACILITY	-752	931,481	44.00
45.00	04500	NURSING FACILITY	0	669,481	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,264,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	15,535	52.01
53.00	05300	ANESTHESIOLOGY	-1,553,030	57,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,686,853	54.00
57.00	05700	CT SCAN	0	268,379	57.00
58.00	05800	MRI	0	180,081	58.00
60.00	06000	LABORATORY	-75,672	3,434,486	60.00
65.00	06500	RESPIRATORY THERAPY	0	704,446	65.00
66.00	06600	PHYSICAL THERAPY	0	1,805,703	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	792,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,693,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,367,983	73.00
76.97	07697	CARDIAC REHABILITATION	-44,908	204,311	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-7,196	15,199,193	88.00
88.01	08801	ELMWOOD RHC	0	512,039	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-370,645	1,043,181	90.01
91.00	09100	EMERGENCY	-2,167,786	1,395,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-20,625	1,176,375	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,756,902	76,430,307	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	751	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	FOUNDATION	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	194.01
194.02	07952	FRESENIUS	0	0	194.02
194.03	07953	RUCHFORD POB	0	3,971	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	194.05
194.06	07956	LEWISTON POB	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	194.07
194.08	07958	KELLEY HOME	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	194.10
194.11	07961	WELLNESS CENTER	0	69,688	194.11
194.12	07962	ELMWOOD CLINIC	0	236,263	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,756,902	76,740,980	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet Non-CMS W
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
52.01	DELIVERY ROOM & LABOR ROOM	05201		52.01
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	ELMWOOD RHC	08801		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	WOUND CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	CANTON RHC RENTED SPACE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.02	FOUNDATION	19302		193.02
194.00	PHYSICIANS CLINIC	07950		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	07951		194.01
194.02	FRESENIUS	07952		194.02
194.03	RUCHFORD POB	07953		194.03
194.04	EP COLEMAN RENTAL SPACE	07954		194.04
194.05	FARMINGTON POB	07955		194.05
194.06	LEWISTON POB	07956		194.06
194.07	OTHER RENTAL PROPERTY	07957		194.07
194.08	KELLEY HOME	07958		194.08
194.09	EMPLOYEE PURCHASE	07959		194.09
194.10	RETAIL PHARMACY	07960		194.10
194.11	WELLNESS CENTER	07961		194.11
194.12	ELMWOOD CLINIC	07962		194.12
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/16/2020 2:07 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	417,795	353,535		1.00
	TOTALS		417,795	353,535		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	18	0		1.00
	TOTALS		18	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	13,985		1.00
2.00	ELMWOOD RHC	88.01	0	39,737		2.00
3.00	RUCHFORD POB	194.03	0	3,109		3.00
4.00	ELMWOOD CLINIC	194.12	0	19,869		4.00
	TOTALS		0	76,700		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	98,653		1.00
2.00	RUCHFORD POB	194.03	0	862		2.00
	TOTALS		0	99,515		
	E - DEPRECIATION RECLASS					
1.00	CARDIAC REHABILITATION	76.97	0	18,905		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,851,167		2.00
	TOTALS		0	2,870,072		
	F - RHC EXPENSE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	121,794	0		1.00
2.00	ELMWOOD RHC	88.01	161,447	310,855		2.00
3.00	ELMWOOD CLINIC	194.12	73,970	142,424		3.00
	TOTALS		357,211	453,279		
	G - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,500		1.00
	TOTALS		0	7,500		
	H - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,693,833		1.00
	TOTALS		0	1,693,833		
	I - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	792,278		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	792,278		
	J - RECLASS PHYSICIAN BENEFITS					
1.00	EMERGENCY	91.00	0	66,829		1.00
2.00	WOUND CLINIC	90.01	0	56,622		2.00
	TOTALS		0	123,451		
	K - RECLASS OB SALARIES					
1.00	NURSERY	43.00	8,849	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	15,535	0		2.00
	TOTALS		24,384	0		
500.00	Grand Total: Increases		799,408	6,470,163		500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
11/16/2020 2:07 pm

	Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	417,795	353,535	0	1.00
	TOTALS		417,795	353,535		
	B - MAINTENANCE LABOR RECLASS					
1.00	OPERATION OF PLANT	7.00	18	0	0	1.00
	TOTALS		18	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	76,700	9	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	76,700		
	D - PROPERTY INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	99,515	12	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	99,515		
	E - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,870,072	9	1.00
2.00		0.00	0	0	9	2.00
	TOTALS		0	2,870,072		
	F - RHC EXPENSE RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	357,211	453,279	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		357,211	453,279		
	G - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,500	0	1.00
	TOTALS		0	7,500		
	H - IMPLANT RECLASS					
1.00	OPERATING ROOM	50.00	0	1,693,833	0	1.00
	TOTALS		0	1,693,833		
	I - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	11,059	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,945	0	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	66	0	3.00
4.00	OPERATING ROOM	50.00	0	719,875	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,652	0	5.00
6.00	WOUND CLINIC	90.01	0	45,170	0	6.00
7.00	EMERGENCY	91.00	0	11,511	0	7.00
	TOTALS		0	792,278		
	J - RECLASS PHYSICIAN BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	123,451	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	123,451		
	K - RECLASS OB SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	24,384	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		24,384	0		
500.00	Grand Total: Decreases		799,408	6,470,163		500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/16/2020 2:07 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	417,795	353,535	DIETARY	10.00	417,795	353,535	1.00
	TOTALS		417,795	353,535	TOTALS		417,795	353,535	
B - MAINTENANCE LABOR RECLASS									
1.00	PHYSICIANS PRIVATE OFFICES	192.00	18	0	OPERATION OF PLANT	7.00	18	0	1.00
	TOTALS		18	0	TOTALS		18	0	
C - OFFSITE CAPITAL RECLASS									
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	13,985	CAP REL COSTS-BLDG & FIXT	1.00	0	76,700	1.00
2.00	ELMWOOD RHC	88.01	0	39,737		0.00	0	0	2.00
3.00	RUCHFORD POB	194.03	0	3,109		0.00	0	0	3.00
4.00	ELMWOOD CLINIC	194.12	0	19,869		0.00	0	0	4.00
	TOTALS		0	76,700	TOTALS		0	76,700	
D - PROPERTY INSURANCE RECLASS									
1.00	OTHER CAP REL COSTS	3.00	0	98,653	ADMINISTRATIVE & GENERAL	5.00	0	99,515	1.00
2.00	RUCHFORD POB	194.03	0	862		0.00	0	0	2.00
	TOTALS		0	99,515	TOTALS		0	99,515	
E - DEPRECIATION RECLASS									
1.00	CARDIAC REHABILITATION	76.97	0	18,905	CAP REL COSTS-BLDG & FIXT	1.00	0	2,870,072	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,851,167		0.00	0	0	2.00
	TOTALS		0	2,870,072	TOTALS		0	2,870,072	
F - RHC EXPENSE RECLASS									
1.00	ADULTS & PEDIATRICS	30.00	121,794	0	RURAL HEALTH CLINIC	88.00	357,211	453,279	1.00
2.00	ELMWOOD RHC	88.01	161,447	310,855		0.00	0	0	2.00
3.00	ELMWOOD CLINIC	194.12	73,970	142,424		0.00	0	0	3.00
	TOTALS		357,211	453,279	TOTALS		357,211	453,279	
G - EMPLOYEE BENEFIT AUDIT RECLASS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,500	ADMINISTRATIVE & GENERAL	5.00	0	7,500	1.00
	TOTALS		0	7,500	TOTALS		0	7,500	
H - IMPLANT RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,693,833	OPERATING ROOM	50.00	0	1,693,833	1.00
	TOTALS		0	1,693,833	TOTALS		0	1,693,833	
I - MED SUP CHARGE TO PATIENTS RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	792,278	ADULTS & PEDIATRICS	30.00	0	11,059	1.00
2.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	2,945	2.00
3.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	66	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	719,875	4.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,652	5.00
6.00		0.00	0	0	WOUND CLINIC	90.01	0	45,170	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	11,511	7.00
	TOTALS		0	792,278	TOTALS		0	792,278	
J - RECLASS PHYSICIAN BENEFITS									
1.00	EMERGENCY	91.00	0	66,829	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	123,451	1.00
2.00	WOUND CLINIC	90.01	0	56,622		0.00	0	0	2.00
	TOTALS		0	123,451	TOTALS		0	123,451	
K - RECLASS OB SALARIES									
1.00	NURSERY	43.00	8,849	0	ADULTS & PEDIATRICS	30.00	24,384	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	15,535	0		0.00	0	0	2.00
	TOTALS		24,384	0	TOTALS		24,384	0	
500.00	Grand Total: Increases		799,408	6,470,163	Grand Total: Decreases		799,408	6,470,163	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,733,107	139,104	0	139,104	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	87,498,396	424,850	0	424,850	52,918	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,555,983	1,933,588	0	1,933,588	0	5.00
6.00	Movable Equipment	34,883,021	2,106,480	0	2,106,480	42,665	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,670,507	4,604,022	0	4,604,022	95,583	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	137,670,507	4,604,022	0	4,604,022	95,583	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,872,211	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	87,870,328	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	11,489,571	0				5.00
6.00	Movable Equipment	36,946,836	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	142,178,946	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	142,178,946	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,659,626	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,659,626	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	7,659,626				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7,659,626				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	105,232,110	0	105,232,110	0.740138	73,017	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,946,836	0	36,946,836	0.259862	25,636	2.00
3.00	Total (sum of lines 1-2)	142,178,946	0	142,178,946	1.000000	98,653	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	73,017	4,712,854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	25,636	2,847,332	0	2.00
3.00	Total (sum of lines 1-2)	0	0	98,653	7,560,186	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-679,098	73,017	0	0	4,106,773	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	25,636	0	0	2,872,968	2.00
3.00	Total (sum of lines 1-2)	-679,098	98,653	0	0	6,979,741	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-181,259	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-42,650	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-6,212	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,821	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,759,670			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-278,035	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		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-26,751	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		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: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
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	DIETARY VENDOR REBATES/REFUNDS	B	-2,114	DIETARY	10.00	0	33.00
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MEDICAL STAFF DUES	B	-17,138	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER INCOME & PURCHASE GROUP	B	-97,074	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HOUSKEEPING OTHER REVENUE	B	-3,120	HOUSEKEEPING	9.00	0	33.05
33.06	DIETARY CONSULTANT AND EMP PURCHASE	B	-297,686	DIETARY	10.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	NRSNG SVS CPR CLASS FEES	B	-3,716	NURSING ADMINISTRATION	13.00	0	33.09
33.10	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-135,265	PHARMACY	15.00	0	33.10
33.11	REFUND/EXP REBATE	B	-892	PHARMACY	15.00	0	33.11
33.12	CARDIAC OTHER REVENUE	B	-28,330	CARDIAC REHABILITATION	76.97	0	33.12
33.15	RHC OTHER INCOME	B	-7,196	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	HME NON PATIENT SALES	B	-7,951	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.16
33.17	HME HME OTHER REVENUE	B	-7,334	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.17
33.18	LAB OTHER REVENUE	B	-3,872	LABORATORY	60.00	0	33.18
33.20	NURSNG SCHOOL(TUITN FEES BOOKS ETC.)	B	-248,076	NURSING SCHOOL	20.00	0	33.20
33.21	DONATIONS & DUES	A	-40,268	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	CRNA SALARIES EXPENSE	A	-1,553,030	ANESTHESIOLOGY	53.00	0	33.23
33.26	CRNA BENEFITS EXPENSE	A	-336,640	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	LAB REFUND/REBATES	B	-1,232	LABORATORY	60.00	0	33.28
33.29	IL HOSPITAL PROVIDER TAX	A	-2,256,838	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	PHONE SALARIES EXPENSE	A	-2,988	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PHONE BENEFIT EXPENSE	A	-648	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	PHONE OTHER EXPENSE	A	-2,053	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHONE DEPREPATION M/M EXPENSE	A	-14	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.34
33.35	IHA & AHA DUES LOBBYING PORTION	A	-22,680	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	IL HEALTHCARE ASSOCIATION LOBBYING	A	-752	SKILLED NURSING FACILITY	44.00	0	33.36
33.38	MARKETING DEPT SALARY EXPENSE	A	-121,115	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MARKETING DEPT BENEIFT EXPENSE	A	-26,253	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	MARKETING DEPT OTHER EXPENSE	A	-460,115	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.43	PHYSICIAN RECRUITMENT	A	-304,841	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	LOAN FORGIVENESS EXPENSE	A	-397,457	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	RETAIL PHARMACY EXPENSES	A	-1,567,651	PHARMACY	15.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	SWAP INTEREST RATE EXPENSE	A	-497,839	CAP REL COSTS-BLDG & FIXT	1.00	11	33.47
33.49	GRI HME EMPLOYEE & GUEST REVENUE	B	-5,340	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.49
33.50	EMERGENCY ROOM OTHER INCOME	B	-986	EMERGENCY	91.00	0	33.50
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,756,902				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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		11/16/2025 2:07 pm	
			Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/16/2020 2:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,171,497	2,148,443	23,054	171,400	57	1.00
2.00	90.01	WOUND CLINIC	378,556	366,556	12,000	171,400	96	2.00
3.00	76.97	CARDIAC REHABILITATION	16,578	16,578	0	0	0	3.00
4.00	60.00	LABORATORY	57,000	0	57,000	171,400	500	4.00
5.00	60.00	LABORATORY	54,770	54,770	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	135,079	135,079	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,813,480	2,721,426	92,054		653	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	4,697	235	0	0	0	1.00
2.00	90.01	WOUND CLINIC	7,911	396	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	41,202	2,060	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			53,810	2,691	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	4,697	18,357	2,166,800		1.00
2.00	90.01	WOUND CLINIC	0	7,911	4,089	370,645		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	16,578		3.00
4.00	60.00	LABORATORY	0	41,202	15,798	15,798		4.00
5.00	60.00	LABORATORY	0	0	0	54,770		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	135,079		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	53,810	38,244	2,759,670		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,106,773	4,106,773			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,872,968	2,872,968			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,754,235	16,409	11,479	8,782,123	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,200,332	392,519	274,594	1,846,145	5.00
7.00	00700	OPERATION OF PLANT	2,912,804	371,120	259,624	249,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	232,514	80,708	56,461	8,235	8.00
9.00	00900	HOUSEKEEPING	1,046,966	65,252	45,648	268,921	9.00
10.00	01000	DIETARY	216,384	133,577	93,446	88,730	10.00
11.00	01100	CAFETERIA	493,295	31,367	21,943	128,321	11.00
13.00	01300	NURSING ADMINISTRATION	985,364	31,367	21,943	203,400	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,694	30,567	0	14.00
15.00	01500	PHARMACY	723,402	42,333	29,615	234,121	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	625,794	64,412	45,061	123,005	16.00
20.00	02000	NURSING SCHOOL	1,112,613	371,086	259,600	345,245	20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,995,391	288,076	201,529	1,063,076	30.00
31.00	03100	INTENSIVE CARE UNIT	717,469	28,645	20,039	209,210	31.00
43.00	04300	NURSERY	31,510	10,104	7,069	2,718	43.00
44.00	04400	SKILLED NURSING FACILITY	931,481	68,166	47,687	257,114	44.00
45.00	04500	NURSING FACILITY	669,481	60,024	41,991	194,695	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,264,342	228,063	159,546	462,390	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	15,535	4,672	3,269	4,771	52.01
53.00	05300	ANESTHESIOLOGY	57,205	3,572	2,499	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,853	132,023	92,359	250,794	54.00
57.00	05700	CT SCAN	268,379	0	0	20,593	57.00
58.00	05800	MRI	180,081	33,692	23,570	19,440	58.00
60.00	06000	LABORATORY	3,434,486	151,642	106,084	459,234	60.00
65.00	06500	RESPIRATORY THERAPY	704,446	22,454	15,708	187,029	65.00
66.00	06600	PHYSICAL THERAPY	1,805,703	86,877	60,777	10,399	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	792,278	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,693,833	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,367,983	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	204,311	97,413	68,147	39,985	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,199,193	670,018	468,719	1,463,120	88.00
88.01	08801	ELMWOOD RHC	512,039	38,375	26,846	49,587	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,043,181	47,765	33,415	89,018	90.01
91.00	09100	EMERGENCY	1,395,308	134,189	93,874	345,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,176,375	1,735	1,214	119,556	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,430,307	3,751,349	2,624,323	8,744,815	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,180	4,324	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	751	40,269	28,171	6	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	116,317	81,371	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	31,514	22,047	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	68,041	47,600	0	194.02
194.03	07953	RUCHFORD POB	3,971	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	75,673	52,939	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	69,688	0	0	14,583	194.11
194.12	07962	ELMWOOD CLINIC	236,263	17,430	12,193	22,719	194.12
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,740,980	4,106,773	2,872,968	8,782,123	76,740,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,713,590					5.00
7.00	00700	OPERATION OF PLANT	825,404	4,618,951				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,228	112,059	572,205			8.00
9.00	00900	HOUSEKEEPING	310,442	90,598	0	1,827,827		9.00
10.00	01000	DIETARY	115,783	185,463	0	116,499	949,882	10.00
11.00	01100	CAFETERIA	146,851	43,551	0	27,357	0	11.00
13.00	01300	NURSING ADMINISTRATION	270,252	43,551	0	27,357	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,158	60,666	0	38,108	0	14.00
15.00	01500	PHARMACY	223,993	58,777	0	36,921	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	186,744	89,433	0	56,178	0	16.00
20.00	02000	NURSING SCHOOL	454,427	515,230	0	323,646	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,207,155	399,975	251,863	251,246	428,409	30.00
31.00	03100	INTENSIVE CARE UNIT	212,220	39,772	32,283	24,983	54,913	31.00
43.00	04300	NURSERY	11,184	14,029	13,769	8,812	0	43.00
44.00	04400	SKILLED NURSING FACILITY	283,823	94,644	97,944	59,451	166,600	44.00
45.00	04500	NURSING FACILITY	210,225	83,339	172,962	52,350	294,203	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	677,621	316,652	0	198,906	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	6,146	6,487	3,384	4,075	5,757	52.01
53.00	05300	ANESTHESIOLOGY	13,768	4,960	0	3,115	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,416	183,306	0	115,144	0	54.00
57.00	05700	CT SCAN	62,875	0	0	0	0	57.00
58.00	05800	MRI	55,871	46,779	0	29,384	0	58.00
60.00	06000	LABORATORY	903,276	210,545	0	132,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	202,271	31,176	0	19,583	0	65.00
66.00	06600	PHYSICAL THERAPY	427,276	120,624	0	75,770	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	172,385	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	368,546	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	515,228	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	89,177	135,251	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,873,197	930,275	0	0	0	88.00
88.01	08801	ELMWOOD RHC	136,390	53,282	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	264,008	66,319	0	41,658	0	90.01
91.00	09100	EMERGENCY	428,490	186,313	0	117,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	282,612	2,409	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,506,442	4,125,465	572,205	1,759,831	949,882	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,285	8,581	0	5,390	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	15,056	55,911	0	35,121	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	43,013	161,499	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	11,654	43,756	0	27,485	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	25,161	94,471	0	0	0	194.02
194.03	07953	RUCHFORD POB	864	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	27,984	105,068	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	18,336	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	62,795	24,200	0	0	0	194.12
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)	13,713,590	4,618,951	572,205	1,827,827	949,882	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	892,685					11.00
13.00	01300	NURSING ADMINISTRATION	39,345	1,622,579				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	189,193			14.00
15.00	01500	PHARMACY	45,288	0	0	1,394,450		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,794	0	0	0	1,214,421	16.00
20.00	02000	NURSING SCHOOL	66,783	0	90	220	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	205,638	624,248	7,959	13,356	90,282	30.00
31.00	03100	INTENSIVE CARE UNIT	40,469	114,183	1,413	3,435	16,210	31.00
43.00	04300	NURSERY	526	59,001	836	5	2,160	43.00
44.00	04400	SKILLED NURSING FACILITY	49,736	182,175	1,430	1,946	8,499	44.00
45.00	04500	NURSING FACILITY	37,661	177,618	845	678	5,732	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,444	300,177	22,436	13,982	153,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	923	18,107	0	0	4,632	52.01
53.00	05300	ANESTHESIOLOGY	0	74,890	810	54	46,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,513	0	5,816	3,990	114,056	54.00
57.00	05700	CT SCAN	3,983	0	2,151	144	104,864	57.00
58.00	05800	MRI	3,760	0	524	0	27,543	58.00
60.00	06000	LABORATORY	88,833	0	3,775	305	170,076	60.00
65.00	06500	RESPIRATORY THERAPY	36,178	0	2,209	117	29,768	65.00
66.00	06600	PHYSICAL THERAPY	2,012	0	275	20	50,349	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	35,818	0	25,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	76,575	0	31,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,374	1,049,835	76,155	73.00
76.97	07697	CARDIAC REHABILITATION	7,735	0	73	252	4,747	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,923	0	8,538	287,694	113,693	88.00
88.01	08801	ELMWOOD RHC	0	0	0	0	1,781	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	17,219	72,180	6,583	8,502	26,492	90.01
91.00	09100	EMERGENCY	66,922	0	5,833	9,879	109,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	817	36	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	892,685	1,622,579	189,180	1,394,450	1,213,613	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	0	13	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	0	0	0	0	808	194.12
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	892,685	1,622,579	189,193	1,394,450	1,214,421	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL	3,448,940				20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	563,187	9,591,390	0	9,591,390	30.00
31.00	03100	INTENSIVE CARE UNIT	158,169	1,673,413	0	1,673,413	31.00
43.00	04300	NURSERY	0	161,723	0	161,723	43.00
44.00	04400	SKILLED NURSING FACILITY	1,113,137	3,363,833	0	3,363,833	44.00
45.00	04500	NURSING FACILITY	0	2,001,804	0	2,001,804	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	731,282	5,618,513	0	5,618,513	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	77,758	0	77,758	52.01
53.00	05300	ANESTHESIOLOGY	0	207,790	0	207,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,103,270	0	3,103,270	54.00
57.00	05700	CT SCAN	0	462,989	0	462,989	57.00
58.00	05800	MRI	0	420,644	0	420,644	58.00
60.00	06000	LABORATORY	0	5,660,511	0	5,660,511	60.00
65.00	06500	RESPIRATORY THERAPY	97,284	1,348,223	0	1,348,223	65.00
66.00	06600	PHYSICAL THERAPY	81,732	2,721,814	0	2,721,814	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,025,633	0	1,025,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,170,781	0	2,170,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,013,575	0	4,013,575	73.00
76.97	07697	CARDIAC REHABILITATION	107,211	754,302	0	754,302	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	250,158	23,282,528	0	23,282,528	88.00
88.01	08801	ELMWOOD RHC	0	818,300	0	818,300	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	81,401	1,797,741	0	1,797,741	90.01
91.00	09100	EMERGENCY	265,379	3,158,190	0	3,158,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,584,754	0	1,584,754	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,448,940	75,019,479	0	75,019,479	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	26,760	0	26,760	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	175,298	0	175,298	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	402,200	0	402,200	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	136,456	0	136,456	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	235,273	0	235,273	194.02
194.03	07953	RUCHFORD POB	0	4,835	0	4,835	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	261,664	0	261,664	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	102,607	0	102,607	194.11
194.12	07962	ELMWOOD CLINIC	0	376,408	0	376,408	194.12
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,448,940	76,740,980	0	76,740,980	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0001

Period:

From 07/01/2019

To 06/30/2020

Worksheet Non-CMS W

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALA RIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	51	TOTAL PATIENT DAYS	8.00
9.00	HOUSEKEEPING	7	SQUARE FEET	9.00
10.00	DIETARY	52	TOTAL PATIENT DAYS	10.00
11.00	CAFETERIA	55	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	24	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	18	GROSS CHARGES	16.00
20.00	NURSING SCHOOL	14	ASSIGNED TIME	20.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,409	11,479	27,888	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	392,519	274,594	667,113	5.00
7.00	00700	OPERATION OF PLANT	0	371,120	259,624	630,744	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,708	56,461	137,169	8.00
9.00	00900	HOUSEKEEPING	0	65,252	45,648	110,900	9.00
10.00	01000	DIETARY	0	133,577	93,446	227,023	10.00
11.00	01100	CAFETERIA	0	31,367	21,943	53,310	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,367	21,943	53,310	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,694	30,567	74,261	14.00
15.00	01500	PHARMACY	0	42,333	29,615	71,948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,412	45,061	109,473	16.00
20.00	02000	NURSING SCHOOL	0	371,086	259,600	630,686	20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	288,076	201,529	489,605	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,645	20,039	48,684	31.00
43.00	04300	NURSERY	0	10,104	7,069	17,173	43.00
44.00	04400	SKILLED NURSING FACILITY	0	68,166	47,687	115,853	44.00
45.00	04500	NURSING FACILITY	0	60,024	41,991	102,015	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	228,063	159,546	387,609	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	4,672	3,269	7,941	52.01
53.00	05300	ANESTHESIOLOGY	0	3,572	2,499	6,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,023	92,359	224,382	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	33,692	23,570	57,262	58.00
60.00	06000	LABORATORY	0	151,642	106,084	257,726	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,454	15,708	38,162	65.00
66.00	06600	PHYSICAL THERAPY	0	86,877	60,777	147,654	66.00
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
76.97	07697	CARDIAC REHABILITATION	0	97,413	68,147	165,560	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	670,018	468,719	1,138,737	88.00
88.01	08801	ELMWOOD RHC	0	38,375	26,846	65,221	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	47,765	33,415	81,180	90.01
91.00	09100	EMERGENCY	0	134,189	93,874	228,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,735	1,214	2,949	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,751,349	2,624,323	6,375,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,180	4,324	10,504	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	40,269	28,171	68,440	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	116,317	81,371	197,688	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	31,514	22,047	53,561	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	68,041	47,600	115,641	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	75,673	52,939	128,612	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	0	17,430	12,193	29,623	194.12
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
			1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	0	4,106,773	2,872,968	6,979,741	27,888	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			ADMINISTRATIVE E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	672,982					5.00
7.00	00700	OPERATION OF PLANT	40,507	672,045				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,035	16,304	157,534			8.00
9.00	00900	HOUSEKEEPING	15,235	13,182	0	140,171		9.00
10.00	01000	DIETARY	5,682	26,984	0	8,934	268,905	10.00
11.00	01100	CAFETERIA	7,207	6,337	0	2,098	0	11.00
13.00	01300	NURSING ADMINISTRATION	13,263	6,337	0	2,098	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	793	8,827	0	2,922	0	14.00
15.00	01500	PHARMACY	10,993	8,552	0	2,831	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,165	13,012	0	4,308	0	16.00
20.00	02000	NURSING SCHOOL	22,301	74,965	0	24,820	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	59,242	58,195	69,340	19,267	121,280	30.00
31.00	03100	INTENSIVE CARE UNIT	10,415	5,787	8,888	1,916	15,545	31.00
43.00	04300	NURSERY	549	2,041	3,791	676	0	43.00
44.00	04400	SKILLED NURSING FACILITY	13,929	13,771	26,965	4,559	47,163	44.00
45.00	04500	NURSING FACILITY	10,317	12,126	47,618	4,015	83,287	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,255	46,072	0	15,254	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	302	944	932	312	1,630	52.01
53.00	05300	ANESTHESIOLOGY	676	722	0	239	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,086	26,670	0	8,830	0	54.00
57.00	05700	CT SCAN	3,086	0	0	0	0	57.00
58.00	05800	MRI	2,742	6,806	0	2,253	0	58.00
60.00	06000	LABORATORY	44,329	30,634	0	10,142	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,927	4,536	0	1,502	0	65.00
66.00	06600	PHYSICAL THERAPY	20,969	17,550	0	5,811	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,460	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,087	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,285	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	4,376	19,679	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	190,056	135,351	0	0	0	88.00
88.01	08801	ELMWOOD RHC	6,693	7,752	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	12,956	9,649	0	3,195	0	90.01
91.00	09100	EMERGENCY	21,029	27,108	0	8,975	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	13,869	351	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	662,816	600,244	157,534	134,957	268,905	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	112	1,249	0	413	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	739	8,135	0	2,693	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	2,111	23,498	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	572	6,366	0	2,108	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	1,235	13,745	0	0	0	194.02
194.03	07953	RUCHFORD POB	42	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	1,373	15,287	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	900	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	3,082	3,521	0	0	0	194.12
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)	672,982	672,045	157,534	140,171	268,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	69,359					11.00
13.00	01300	NURSING ADMINISTRATION	3,057	78,711				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	86,803			14.00
15.00	01500	PHARMACY	3,519	0	0	98,586		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,849	0	0	0	138,197	16.00
20.00	02000	NURSING SCHOOL	5,189	0	41	16	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,979	30,283	3,652	944	10,279	30.00
31.00	03100	INTENSIVE CARE UNIT	3,144	5,539	648	243	1,846	31.00
43.00	04300	NURSERY	41	2,862	384	0	246	43.00
44.00	04400	SKILLED NURSING FACILITY	3,864	8,837	656	138	968	44.00
45.00	04500	NURSING FACILITY	2,926	8,616	388	48	653	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,949	14,562	10,294	988	17,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	72	878	0	0	527	52.01
53.00	05300	ANESTHESIOLOGY	0	3,633	372	4	5,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,769	0	2,668	282	12,986	54.00
57.00	05700	CT SCAN	309	0	987	109	11,939	57.00
58.00	05800	MRI	292	0	240	0	3,136	58.00
60.00	06000	LABORATORY	6,902	0	1,732	22	19,292	60.00
65.00	06500	RESPIRATORY THERAPY	2,811	0	1,013	8	3,389	65.00
66.00	06600	PHYSICAL THERAPY	156	0	126	1	5,732	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,433	0	2,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,135	0	3,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,007	74,222	8,671	73.00
76.97	07697	CARDIAC REHABILITATION	601	0	33	18	541	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,392	0	3,917	20,340	12,944	88.00
88.01	08801	ELMWOOD RHC	0	0	0	0	203	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,338	3,501	3,020	601	3,016	90.01
91.00	09100	EMERGENCY	5,200	0	2,676	698	12,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	375	3	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,359	78,711	86,797	98,586	138,195	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	0	6	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	0	0	0	0	92	194.12
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)	69,359	78,711	86,803	98,586	138,197	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
20.00	02000	NURSING SCHOOL	759,114				20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		881,441	0	881,441	30.00
31.00	03100	INTENSIVE CARE UNIT		103,319	0	103,319	31.00
43.00	04300	NURSERY		27,772	0	27,772	43.00
44.00	04400	SKILLED NURSING FACILITY		237,519	0	237,519	44.00
45.00	04500	NURSING FACILITY		272,627	0	272,627	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		533,947	0	533,947	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		13,553	0	13,553	52.01
53.00	05300	ANESTHESIOLOGY		17,059	0	17,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		303,469	0	303,469	54.00
57.00	05700	CT SCAN		16,396	0	16,396	57.00
58.00	05800	MRI		72,793	0	72,793	58.00
60.00	06000	LABORATORY		372,237	0	372,237	60.00
65.00	06500	RESPIRATORY THERAPY		61,942	0	61,942	65.00
66.00	06600	PHYSICAL THERAPY		198,032	0	198,032	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		27,757	0	27,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		56,846	0	56,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		110,185	0	110,185	73.00
76.97	07697	CARDIAC REHABILITATION		190,935	0	190,935	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		1,507,382	0	1,507,382	88.00
88.01	08801	ELMWOOD RHC		80,026	0	80,026	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000	CLINIC		0	0	0	90.00
90.01	09001	WOUND CLINIC		118,739	0	118,739	90.01
91.00	09100	EMERGENCY		307,258	0	307,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		17,927	0	17,927	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,529,161	0	5,529,161	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN		12,278	0	12,278	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		80,013	0	80,013	192.00
192.01	19201	CANTON RHC RENTED SPACE		223,297	0	223,297	192.01
193.00	19300	NONPAID WORKERS		0	0	0	193.00
193.02	19302	FOUNDATION		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC		62,607	0	62,607	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY		0	0	0	194.01
194.02	07952	FRESENIUS		130,621	0	130,621	194.02
194.03	07953	RUCHFORD POB		42	0	42	194.03
194.04	07954	EP COLEMAN RENTAL SPACE		145,272	0	145,272	194.04
194.05	07955	FARMINGTON POB		0	0	0	194.05
194.06	07956	LEWISTON POB		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY		0	0	0	194.07
194.08	07958	KELLEY HOME		0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE		0	0	0	194.09
194.10	07960	RETAIL PHARMACY		0	0	0	194.10
194.11	07961	WELLNESS CENTER		946	0	946	194.11
194.12	07962	ELMWOOD CLINIC		36,390	0	36,390	194.12
200.00		Cross Foot Adjustments	759,114	759,114	0	759,114	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	759,114	6,979,741	0	6,979,741	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,142					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		362,142				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,447	1,447	28,593,424			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,613	34,613	6,010,809	-13,713,590	63,027,390	5.00
7.00	00700	OPERATION OF PLANT	32,726	32,726	813,964	0	3,793,547	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	7,117	26,811	0	377,918	8.00
9.00	00900	HOUSEKEEPING	5,754	5,754	875,571	0	1,426,787	9.00
10.00	01000	DIETARY	11,779	11,779	288,894	0	532,137	10.00
11.00	01100	CAFETERIA	2,766	2,766	417,795	0	674,926	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	2,766	662,242	0	1,242,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	3,853	0	0	74,261	14.00
15.00	01500	PHARMACY	3,733	3,733	762,268	0	1,029,471	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	5,680	400,488	0	858,272	16.00
20.00	02000	NURSING SCHOOL	32,723	32,723	1,124,071	0	2,088,544	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,403	25,403	3,461,234	0	5,548,072	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	2,526	681,158	0	975,363	31.00
43.00	04300	NURSERY	891	891	8,849	0	51,401	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	6,011	837,130	0	1,304,448	44.00
45.00	04500	NURSING FACILITY	5,293	5,293	633,902	0	966,191	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,111	20,111	1,505,480	0	3,114,341	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	412	412	15,535	0	28,247	52.01
53.00	05300	ANESTHESIOLOGY	315	315	0	0	63,276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,642	11,642	816,550	0	2,162,029	54.00
57.00	05700	CT SCAN	0	0	67,048	0	288,972	57.00
58.00	05800	MRI	2,971	2,971	63,295	0	256,783	58.00
60.00	06000	LABORATORY	13,372	13,372	1,495,205	0	4,151,446	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	1,980	608,942	0	929,637	65.00
66.00	06600	PHYSICAL THERAPY	7,661	7,661	33,857	0	1,963,756	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	792,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,693,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,367,983	73.00
76.97	07697	CARDIAC REHABILITATION	8,590	8,590	130,185	0	409,856	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,083	59,083	4,763,722	0	17,801,050	88.00
88.01	08801	ELMWOOD RHC	3,384	3,384	161,447	0	626,847	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	4,212	289,832	0	1,213,379	90.01
91.00	09100	EMERGENCY	11,833	11,833	1,126,412	0	1,969,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	153	389,259	0	1,298,880	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	330,800	330,800	28,471,955	-13,713,590	62,075,340	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	545	0	0	10,504	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	3,551	18	0	69,197	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	10,257	0	0	197,688	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	2,779	0	0	53,561	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	6,000	0	0	115,641	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	3,971	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	6,673	0	0	128,612	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	47,481	0	84,271	194.11
194.12	07962	ELMWOOD CLINIC	1,537	1,537	73,970	0	288,605	194.12
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,106,773	2,872,968	8,782,123		13,713,590	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.340228	7.933264	0.307138		0.217581	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			27,888		672,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000975		0.010678	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: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	293,356					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	17,246				8.00
9.00	00900	HOUSEKEEPING	5,754	0	184,808			9.00
10.00	01000	DIETARY	11,779	0	11,779	16,831		10.00
11.00	01100	CAFETERIA	2,766	0	2,766	0	15,025,351	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	0	2,766	0	662,242	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	0	3,853	0	0	14.00
15.00	01500	PHARMACY	3,733	0	3,733	0	762,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	0	5,680	0	400,488	16.00
20.00	02000	NURSING SCHOOL	32,723	0	32,723	0	1,124,071	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,403	7,591	25,403	7,591	3,461,234	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	973	2,526	973	681,158	31.00
43.00	04300	NURSERY	891	415	891	0	8,849	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	2,952	6,011	2,952	837,130	44.00
45.00	04500	NURSING FACILITY	5,293	5,213	5,293	5,213	633,902	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,111	0	20,111	0	1,505,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	412	102	412	102	15,535	52.01
53.00	05300	ANESTHESIOLOGY	315	0	315	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,642	0	11,642	0	816,550	54.00
57.00	05700	CT SCAN	0	0	0	0	67,048	57.00
58.00	05800	MRI	2,971	0	2,971	0	63,295	58.00
60.00	06000	LABORATORY	13,372	0	13,372	0	1,495,205	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	0	1,980	0	608,942	65.00
66.00	06600	PHYSICAL THERAPY	7,661	0	7,661	0	33,857	66.00
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
76.97	07697	CARDIAC REHABILITATION	8,590	0	0	0	130,185	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,083	0	0	0	301,668	88.00
88.01	08801	ELMWOOD RHC	3,384	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	0	4,212	0	289,832	90.01
91.00	09100	EMERGENCY	11,833	0	11,833	0	1,126,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,014	17,246	177,933	16,831	15,025,351	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	0	545	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	0	3,551	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	0	2,779	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	1,537	0	0	0	0	194.12
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)	4,618,951	572,205	1,827,827	949,882	892,685	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	15.745207	33.178998	9.890411	56.436457	0.059412	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	672,045	157,534	140,171	268,905	69,359	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.290885	9.134524	0.758468	15.976769	0.004616	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: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			NURSING ADMINISTRATIO N (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING SCHOOL (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,173					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,184,852				14.00
15.00	01500	PHARMACY	0	0	3,056,174			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	203,945,131		16.00
20.00	02000	NURSING SCHOOL	0	1,987	482	0	260,575	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,068	176,053	29,273	15,160,672	42,550	30.00
31.00	03100	INTENSIVE CARE UNIT	927	31,263	7,529	2,722,111	11,950	31.00
43.00	04300	NURSERY	479	18,491	11	362,687	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,479	31,621	4,265	1,427,260	84,100	44.00
45.00	04500	NURSING FACILITY	1,442	18,685	1,486	962,557	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,437	496,270	30,643	25,805,538	55,250	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	147	0	0	777,903	0	52.01
53.00	05300	ANESTHESIOLOGY	608	17,924	118	7,878,671	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	128,642	8,744	19,152,993	0	54.00
57.00	05700	CT SCAN	0	47,587	316	17,609,467	0	57.00
58.00	05800	MRI	0	11,581	0	4,625,143	0	58.00
60.00	06000	LABORATORY	0	83,496	668	28,572,079	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	48,851	256	4,998,908	7,350	65.00
66.00	06600	PHYSICAL THERAPY	0	6,090	43	8,454,920	6,175	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	792,279	0	4,223,707	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,693,833	0	5,344,535	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,740	2,300,895	12,788,421	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,607	552	797,223	8,100	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	188,863	630,530	19,092,003	18,900	88.00
88.01	08801	ELMWOOD RHC	0	0	0	299,010	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	586	145,617	18,633	4,448,779	6,150	90.01
91.00	09100	EMERGENCY	0	129,013	21,652	18,304,896	20,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	18,080	78	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,173	4,184,573	3,056,174	203,809,483	260,575	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	279	0	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	ELMWOOD CLINIC	0	0	0	135,648	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		NURSING ADMINISTRATIO N (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING SCHOOL (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	20.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,622,579	189,193	1,394,450	1,214,421	3,448,940	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	123.174600	0.045209	0.456273	0.005955	13.235882	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,711	86,803	98,586	138,197	759,114	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.975176	0.020742	0.032258	0.000678	2.913227	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/16/2020 2:07 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,591,390		9,591,390	0	9,591,390	30.00
31.00	03100	INTENSIVE CARE UNIT	1,673,413		1,673,413	0	1,673,413	31.00
43.00	04300	NURSERY	161,723		161,723	0	161,723	43.00
44.00	04400	SKILLED NURSING FACILITY	3,363,833		3,363,833	0	3,363,833	44.00
45.00	04500	NURSING FACILITY	2,001,804		2,001,804	0	2,001,804	45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,618,513		5,618,513	0	5,618,513	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	77,758		77,758	0	77,758	52.01
53.00	05300	ANESTHESIOLOGY	207,790		207,790	0	207,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,103,270		3,103,270	0	3,103,270	54.00
57.00	05700	CT SCAN	462,989		462,989	0	462,989	57.00
58.00	05800	MRI	420,644		420,644	0	420,644	58.00
60.00	06000	LABORATORY	5,660,511		5,660,511	15,798	5,676,309	60.00
65.00	06500	RESPIRATORY THERAPY	1,348,223	0	1,348,223	0	1,348,223	65.00
66.00	06600	PHYSICAL THERAPY	2,721,814	0	2,721,814	0	2,721,814	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,025,633		1,025,633	0	1,025,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,170,781		2,170,781	0	2,170,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,013,575		4,013,575	0	4,013,575	73.00
76.97	07697	CARDIAC REHABILITATION	754,302		754,302	0	754,302	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	23,282,528		23,282,528	0	23,282,528	88.00
88.01	08801	ELMWOOD RHC	818,300		818,300	0	818,300	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,797,741		1,797,741	4,089	1,801,830	90.01
91.00	09100	EMERGENCY	3,158,190		3,158,190	18,357	3,176,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,175,781		2,175,781	0	2,175,781	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,584,754		1,584,754	0	1,584,754	96.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	77,195,260	0	77,195,260	38,244	77,233,504	200.00
201.00		Less Observation Beds	2,175,781		2,175,781		2,175,781	201.00
202.00		Total (see instructions)	75,019,479	0	75,019,479	38,244	75,057,723	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet C Part I Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	12,475,711		12,475,711			30.00	
31.00	03100	INTENSIVE CARE UNIT	2,722,112		2,722,112			31.00	
43.00	04300	NURSERY	362,687		362,687			43.00	
44.00	04400	SKILLED NURSING FACILITY	1,427,260		1,427,260			44.00	
45.00	04500	NURSING FACILITY	962,557		962,557			45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,300,136	18,505,402	25,805,538	0.217725	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	677,503	100,401	777,904	0.099958	0.000000	52.01	
53.00	05300	ANESTHESIOLOGY	2,963,050	4,915,621	7,878,671	0.026374	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,901,176	17,251,817	19,152,993	0.162025	0.000000	54.00	
57.00	05700	CT SCAN	2,655,186	14,954,281	17,609,467	0.026292	0.000000	57.00	
58.00	05800	MRI	251,179	4,373,964	4,625,143	0.090947	0.000000	58.00	
60.00	06000	LABORATORY	5,362,502	23,209,578	28,572,080	0.198113	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	2,119,345	2,879,562	4,998,907	0.269704	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,559,546	6,895,374	8,454,920	0.321921	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,411,407	1,812,300	4,223,707	0.242828	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,780,013	2,564,522	5,344,535	0.406168	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,500,858	6,287,563	12,788,421	0.313844	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	831	796,393	797,224	0.946161	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	19,092,003	19,092,003			88.00	
88.01	08801	ELMWOOD RHC	0	299,010	299,010			88.01	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09001	WOUND CLINIC	43,037	4,405,741	4,448,778	0.404098	0.000000	90.01	
91.00	09100	EMERGENCY	3,667,619	14,637,278	18,304,897	0.172533	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	518,932	2,166,029	2,684,961	0.810359	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,814,875	4,814,875	0.329137	0.000000	96.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	58,662,647	149,961,714	208,624,361			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	58,662,647	149,961,714	208,624,361			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.217725		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.099958		52.01
53.00	05300	ANESTHESIOLOGY	0.026374		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162025		54.00
57.00	05700	CT SCAN	0.026292		57.00
58.00	05800	MRI	0.090947		58.00
60.00	06000	LABORATORY	0.198666		60.00
65.00	06500	RESPIRATORY THERAPY	0.269704		65.00
66.00	06600	PHYSICAL THERAPY	0.321921		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242828		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406168		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313844		73.00
76.97	07697	CARDIAC REHABILITATION	0.946161		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	ELMWOOD RHC			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.405017		90.01
91.00	09100	EMERGENCY	0.173535		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.810359		92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.329137		96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	881,441	0	881,441	7,591	116.12	30.00
31.00	INTENSIVE CARE UNIT	103,319		103,319	973	106.19	31.00
43.00	NURSERY	27,772		27,772	415	66.92	43.00
44.00	SKILLED NURSING FACILITY	237,519		237,519	2,952	80.46	44.00
45.00	NURSING FACILITY	272,627		272,627	5,213	52.30	45.00
200.00	Total (lines 30 through 199)	1,522,678		1,522,678	17,144		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	3,171	368,217				
31.00	INTENSIVE CARE UNIT	371	39,396				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	1,912	153,840				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	5,454	561,453				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/16/2020 2:07 pm

				Title XVIII		Hospital	PPS	
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	533,947	25,805,538	0.020691	2,805,746	58,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	13,553	777,904	0.017422	2,981	52	52.01
53.00	05300	ANESTHESIOLOGY	17,059	7,878,671	0.002165	494,308	1,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,469	19,152,993	0.015844	1,014,363	16,072	54.00
57.00	05700	CT SCAN	16,396	17,609,467	0.000931	1,384,633	1,289	57.00
58.00	05800	MRI	72,793	4,625,143	0.015739	131,798	2,074	58.00
60.00	06000	LABORATORY	372,237	28,572,080	0.013028	2,698,274	35,153	60.00
65.00	06500	RESPIRATORY THERAPY	61,942	4,998,907	0.012391	1,211,524	15,012	65.00
66.00	06600	PHYSICAL THERAPY	198,032	8,454,920	0.023422	626,627	14,677	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,757	4,223,707	0.006572	1,093,280	7,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,846	5,344,535	0.010636	1,291,383	13,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,185	12,788,421	0.008616	3,101,068	26,719	73.00
76.97	07697	CARDIAC REHABILITATION	190,935	797,224	0.239500	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,507,382	19,092,003	0.078954	0	0	88.00
88.01	08801	ELMWOOD RHC	80,026	299,010	0.267637	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	118,739	4,448,778	0.026690	19,612	523	90.01
91.00	09100	EMERGENCY	307,258	18,304,897	0.016786	2,010,016	33,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	199,952	2,684,961	0.074471	304,415	22,670	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,927	4,814,875	0.003723	0	0	96.00
200.00		Total (lines 50 through 199)	4,206,435	190,674,034		18,190,028	248,025	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/16/2020 2:07 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	563,187	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	158,169	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	1,113,137	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	1,834,493	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	563,187	7,591	74.19	3,171	30.00		
31.00	03100	INTENSIVE CARE UNIT		158,169	973	162.56	371	31.00		
43.00	04300	NURSERY		0	415	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		1,113,137	2,952	377.08	1,912	44.00		
45.00	04500	NURSING FACILITY		0	5,213	0.00	0	45.00		
200.00		Total (lines 30 through 199)		1,834,493	17,144		5,454	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	235,256	0					30.00	
31.00	03100	INTENSIVE CARE UNIT	60,310	0					31.00	
43.00	04300	NURSERY	0	0					43.00	
44.00	04400	SKILLED NURSING FACILITY	720,977						44.00	
45.00	04500	NURSING FACILITY	0						45.00	
200.00		Total (lines 30 through 199)	1,016,543	0					200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII		Hospital		PPS	
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	731,282	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	97,284	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	81,732	0	0	66.00
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
76.97	07697	CARDIAC REHABILITATION		0	0	107,211	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	250,158	0	0	88.00
88.01	08801	ELMWOOD RHC		0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0	89.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC		0	0	81,401	0	0	90.01
91.00	09100	EMERGENCY		0	0	265,379	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		127,758			92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		0	0	1,742,205	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/16/2020 2:07 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	731,282	731,282	25,805,538	0.028338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	777,904	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	7,878,671	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,152,993	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	17,609,467	0.000000	57.00
58.00	05800	MRI	0	0	0	4,625,143	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	28,572,080	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	97,284	97,284	4,998,907	0.019461	65.00
66.00	06600	PHYSICAL THERAPY	0	81,732	81,732	8,454,920	0.009667	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,223,707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,344,535	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,788,421	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	107,211	107,211	797,224	0.134480	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	250,158	250,158	19,092,003	0.013103	88.00
88.01	08801	ELMWOOD RHC	0	0	0	299,010	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	81,401	81,401	4,448,778	0.018297	90.01
91.00	09100	EMERGENCY	0	265,379	265,379	18,304,897	0.014498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	127,758	127,758	2,684,961	0.047583	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,814,875	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,742,205	1,742,205	190,674,034		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description			Title XVIII		Hospital		PPS
			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	0.028338	2,805,746	79,509	4,703,218	133,280
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	2,981	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	494,308	0	646,652	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,014,363	0	5,015,019	0
57.00	05700	CT SCAN	0.000000	1,384,633	0	5,149,931	0
58.00	05800	MRI	0.000000	131,798	0	1,261,697	0
60.00	06000	LABORATORY	0.000000	2,698,274	0	3,650,145	0
65.00	06500	RESPIRATORY THERAPY	0.019461	1,211,524	23,577	649,463	12,639
66.00	06600	PHYSICAL THERAPY	0.009667	626,627	6,058	42,240	408
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,093,280	0	10,009	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,291,383	0	1,172,279	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,101,068	0	1,885,900	0
76.97	07697	CARDIAC REHABILITATION	0.134480	0	0	395,464	53,182
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.013103	0	0	0	0
88.01	08801	ELMWOOD RHC	0.000000	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
90.01	09001	WOUND CLINIC	0.018297	19,612	359	1,767,335	32,337
91.00	09100	EMERGENCY	0.014498	2,010,016	29,141	3,869,475	56,100
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.047583	304,415	14,485	2,040,491	97,093
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		18,190,028	153,129	32,259,318	385,039

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm

				Title XVIII	Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	ELMWOOD RHC	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.217725	4,703,218	0	0	1,024,008	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		0.099958	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0.026374	646,652	0	0	17,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.162025	5,015,019	0	0	812,558	54.00
57.00	05700	CT SCAN		0.026292	5,149,931	0	0	135,402	57.00
58.00	05800	MRI		0.090947	1,261,697	0	0	114,748	58.00
60.00	06000	LABORATORY		0.198113	3,650,145	0	0	723,141	60.00
65.00	06500	RESPIRATORY THERAPY		0.269704	649,463	0	0	175,163	65.00
66.00	06600	PHYSICAL THERAPY		0.321921	42,240	0	0	13,598	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.242828	10,009	0	0	2,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.406168	1,172,279	0	0	476,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.313844	1,885,900	0	1,728	591,878	73.00
76.97	07697	CARDIAC REHABILITATION		0.946161	395,464	0	0	374,173	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	ELMWOOD RHC							88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER							89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC		0.404098	1,767,335	0	0	714,177	90.01
91.00	09100	EMERGENCY		0.172533	3,869,475	0	0	667,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.810359	2,040,491	0	0	1,653,530	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.329137	0	0	0	0	96.00
200.00		Subtotal (see instructions)			32,259,318	0	1,728	7,495,615	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			32,259,318	0	1,728	7,495,615	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/16/2020 2:07 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	542		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ELMWOOD RHC				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	542		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	542		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001
Component CCN: 14-5572

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm
PPS

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	731,282	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	97,284	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	81,732	0	0	66.00
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
76.97	07697 CARDIAC REHABILITATION	0	0	107,211	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	250,158	0	0	88.00
88.01	08801 ELMWOOD RHC	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CLINIC	0	0	81,401	0	0	90.01
91.00	09100 EMERGENCY	0	0	265,379	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	1,614,447	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		731,282	731,282	25,805,538	0.028338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0		0	0	777,904	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0		0	0	7,878,671	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	19,152,993	0.000000	54.00
57.00	05700	CT SCAN	0		0	0	17,609,467	0.000000	57.00
58.00	05800	MRI	0		0	0	4,625,143	0.000000	58.00
60.00	06000	LABORATORY	0		0	0	28,572,080	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0		97,284	97,284	4,998,907	0.019461	65.00
66.00	06600	PHYSICAL THERAPY	0		81,732	81,732	8,454,920	0.009667	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	4,223,707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	5,344,535	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	12,788,421	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0		107,211	107,211	797,224	0.134480	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		250,158	250,158	19,092,003	0.013103	88.00
88.01	08801	ELMWOOD RHC	0		0	0	299,010	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0.000000	89.00
90.00	09000	CLINIC	0		0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0		81,401	81,401	4,448,778	0.018297	90.01
91.00	09100	EMERGENCY	0		265,379	265,379	18,304,897	0.014498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	2,684,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	4,814,875	0.000000	96.00
200.00		Total (lines 50 through 199)	0		1,614,447	1,614,447	190,674,034		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001
Component CCN: 14-5572

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm

				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.028338	509	14	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,175	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	225	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	12,451	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.019461	320,623	6,240	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.009667	928,164	8,973	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	270,350	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	170,087	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.134480	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.013103	0	0	0	0	88.00
88.01	08801	ELMWOOD RHC	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.018297	6,274	115	0	0	90.01
91.00	09100	EMERGENCY	0.014498	0	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								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,715,858	15,342	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0001

Component CCN:14-5572

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/16/2020 2:07 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
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
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 ELMWOOD RHC	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CLINIC	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/16/2020 2:07 pm	
				Component CCN:14-5572					
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.217725	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.099958	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.026374	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162025	0	1	27	0	0	54.00
57.00	05700	CT SCAN	0.026292	0	0	0	0	0	57.00
58.00	05800	MRI	0.090947	0	0	0	1	0	58.00
60.00	06000	LABORATORY	0.198113	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.269704	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.321921	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242828	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406168	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313844	0	449	1,282	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.946161	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	ELMWOOD RHC							88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER							89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.404098	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.172533	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.810359	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.329137	0	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	450	1,310	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0			201.00
202.00		Net Charges (line 200 - line 201)		0	450	1,310	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/16/2020 2:07 pm	
			Component CCN:14-5572					
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	50.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00			
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	52.01			
53.00	05300	ANESTHESIOLOGY	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4	54.00			
57.00	05700	CT SCAN	0	0	57.00			
58.00	05800	MRI	0	0	58.00			
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			
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	141	402	73.00			
76.97	07697	CARDIAC REHABILITATION	0	0	76.97			
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC			88.00			
88.01	08801	ELMWOOD RHC			88.01			
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00			
90.00	09000	CLINIC	0	0	90.00			
90.01	09001	WOUND CLINIC	0	0	90.01			
91.00	09100	EMERGENCY	0	0	91.00			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00			
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00			
200.00		Subtotal (see instructions)	141	406	200.00			
201.00		Less PBP Clinic Lab. Services-Program	0		201.00			
		Only Charges						
202.00		Net Charges (line 200 - line 201)	141	406	202.00			

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,591	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,591	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)		5,869	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,171	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,591,390	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)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,591,390	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)		9,591,390	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,263.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,006,622	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)		4,006,622	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/16/2020 2:07 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,673,413	973	1,719.85	371	638,064
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,268,177
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,912,863
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					703,179
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					401,154
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,104,333
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,808,530
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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)					1,722
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,263.52
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,175,781

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	881,441	9,591,390	0.091899	2,175,781	199,952	90.00		
91.00	Nursing School cost	563,187	9,591,390	0.058718	2,175,781	127,758	91.00		
92.00	Allied health cost	0	9,591,390	0.000000	2,175,781	0	92.00		
93.00	All other Medical Education	0	9,591,390	0.000000	2,175,781	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,952	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,952	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)		2,952	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,912	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,363,833	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)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,363,833	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)		3,363,833	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1
				Component CCN: 14-5572		Date/Time Prepared: 11/16/2020 2:07 pm
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						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)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					3,363,833	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,139.51	71.00
72.00 Program routine service cost (line 9 x line 71)					2,178,743	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					2,178,743	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					2,178,743	83.00
84.00 Program inpatient ancillary services (see instructions)					510,593	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					2,689,336	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0001 Component CCN:14-5572		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/16/2020 2:07 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/16/2020 2:07 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,941,977		30.00
31.00	03100	INTENSIVE CARE UNIT		1,346,766		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.217725	2,805,746	610,881	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.099958	2,981	298	52.01
53.00	05300	ANESTHESIOLOGY	0.026374	494,308	13,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162025	1,014,363	164,352	54.00
57.00	05700	CT SCAN	0.026292	1,384,633	36,405	57.00
58.00	05800	MRI	0.090947	131,798	11,987	58.00
60.00	06000	LABORATORY	0.198666	2,698,274	536,055	60.00
65.00	06500	RESPIRATORY THERAPY	0.269704	1,211,524	326,753	65.00
66.00	06600	PHYSICAL THERAPY	0.321921	626,627	201,724	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242828	1,093,280	265,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406168	1,291,383	524,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313844	3,101,068	973,252	73.00
76.97	07697	CARDIAC REHABILITATION	0.946161	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	ELMWOOD RHC	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.405017	19,612	7,943	90.01
91.00	09100	EMERGENCY	0.173535	2,010,016	348,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.810359	304,415	246,685	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.329137	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,190,028	4,268,177	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)		18,190,028		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/16/2020 2:07 pm	
		Component CCN:14-5572			
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.217725	509	111	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0.099958	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.026374	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162025	7,175	1,163	54.00
57.00	05700 CT SCAN	0.026292	225	6	57.00
58.00	05800 MRI	0.090947	0	0	58.00
60.00	06000 LABORATORY	0.198666	12,451	2,474	60.00
65.00	06500 RESPIRATORY THERAPY	0.269704	320,623	86,473	65.00
66.00	06600 PHYSICAL THERAPY	0.321921	928,164	298,795	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242828	270,350	65,649	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.406168	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313844	170,087	53,381	73.00
76.97	07697 CARDIAC REHABILITATION	0.946161	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 ELMWOOD RHC	0.000000		0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	0.405017	6,274	2,541	90.01
91.00	09100 EMERGENCY	0.173535	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.810359	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.329137	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,715,858	510,593	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)		1,715,858		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,492,690	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,499,738	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		70,843	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		38.02	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.95	31.00
32.00	Sum of lines 30 and 31		22.90	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.09	33.00
34.00	Disproportionate share adjustment (see instructions)		151,159	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000064927	0.000058422
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		537,133	487,861
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		135,387	365,229
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		500,616	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		6,715,046	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		7,608,075	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,608,075	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		480,278	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		830,371	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		295,566	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		153,129	58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,367,419	59.00
60.00	Primary payer payments		12,209	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,355,210	61.00
62.00	Deductibles billed to program beneficiaries		901,164	62.00
63.00	Coinsurance billed to program beneficiaries		51,392	63.00
64.00	Allowable bad debts (see instructions)		301,834	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		196,192	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		241,106	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,598,846	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		13,182	70.93
70.94	HRR adjustment amount (see instructions)		-82,228	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	245,276	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2020	762,438	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,537,514	71.00
71.01	Sequestration adjustment (see instructions)		159,276	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,804,035	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-425,797	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		38,892	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		3,834	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet DSH

Date/Time Prepared:
11/16/2020 2:07 pm

		Title XVIII		Hospital		PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.95	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	19.95	0.00			19.95	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.90	0.00			19.95	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	SCH				SCH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	38.02	0.00			38.02	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	10.09	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,286	0			1,286	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	162	0			162	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,448	0			1,448	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,257	0			7,257	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	7,257	0			7,257	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	19.95	0.00			19.95	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0001		Period: From 07/01/2019 To 06/30/2020		Worksheet DSH Date/Time Prepared: 11/16/2020 2:07 pm	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.11		0.00	False	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00	
30.00	Line 28 or 29 as applicable		8.11		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.11		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet DSH Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.72		29.00
30.00	Line 28 or 29 as applicable	5.72		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/16/2020 2:07 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,492,690	0	1,492,690		1,492,690
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,499,738	0		4,499,738	4,499,738
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	70,843	0		70,843	70,843
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1009	0.1009	0.1009	0.1009	
11.00	Disproportionate share adjustment (see instructions)	34.00	151,159	0	37,653	113,506	151,159
11.01	Uncompensated care payments	36.00	500,616	0	133,348	367,268	500,616
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,715,046	0	1,663,691	5,051,355	6,715,046
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,608,075	0	1,854,168	5,753,907	7,608,075
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,608,075	0	1,854,168	5,753,907	7,608,075

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/16/2020 2:07 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	480,278	0	120,008	360,270	480,278
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,974,176	6,114,177	8,088,353
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	473,383	0	120,008	353,375	473,383
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	6,895	0	0	6,895	6,895
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	480,278	0	120,008	360,270	480,278
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.124242	0.124700	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			245,276		245,276
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				762,438	762,438
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		542	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,110,576	2.00
3.00	OPPS payments		5,716,033	3.00
4.00	Outlier payment (see instructions)		6,054	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.862	5.00
6.00	Line 2 times line 5		6,129,317	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		93.36	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		385,039	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		542	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,728	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)		1,728	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)		1,728	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,186	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)		542	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)		6,107,126	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		90,482	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,052,010	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,965,176	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,965,176	30.00
31.00	Primary payer payments		232	31.00
32.00	Subtotal (line 30 minus line 31)		4,964,944	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)		293,902	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		191,036	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		195,263	36.00
37.00	Subtotal (see instructions)		5,155,980	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,155,980	40.00
40.01	Sequestration adjustment (see instructions)		86,105	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		4,995,237	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)		74,638	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)		327	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/16/2020 2:07 pm	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		547	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		547	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,760	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)		1,760	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)		1,760	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,213	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)		547	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)		49	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		498	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)		498	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		498	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		498	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			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)		498	40.00
40.01	Sequestration adjustment (see instructions)		8	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		1,148	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-658	43.00
43.01	Balance due provider/program-PARHM (see instructions)			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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0001 Component CCN:14-5572	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Skilled Nursing Facility	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/16/2020 2:07 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,610,383		4,878,825	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	02/13/2020	364,847	02/13/2020	116,412	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	10/24/2019	171,195		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		193,652		116,412	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)		9,804,035		4,995,237	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		74,638	6.01
6.02	SETTLEMENT TO PROGRAM		425,797		0	6.02
7.00	Total Medicare program liability (see instructions)		9,378,238		5,069,875	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0001
 Component CCN: 14-5572

 Period:
 From 07/01/2019
 To 06/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/16/2020 2:07 pm

		Title XVIII		Skilled Nursing Facility		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		829,260		1,148	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		829,260		1,148	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		736,319		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		658	6.02
7.00	Total Medicare program liability (see instructions)		1,565,579		490	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0001 Component CCN:14-5572	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		930,573	1.00
2.00	Routine service other pass through costs		720,977	2.00
3.00	Ancillary service other pass through costs		15,342	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,666,892	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		85,916	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,580,976	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,580,976	15.00
15.01	Sequestration adjustment (see instructions)		15,397	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		829,260	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		736,319	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/16/2020 2:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,625,709	0	0	0	1.00
2.00	Temporary investments	20,970,289	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,922,867	0	0	0	4.00
5.00	Other receivable	3,932,009	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,916,268	0	0	0	6.00
7.00	Inventory	2,056,836	0	0	0	7.00
8.00	Prepaid expenses	1,217,144	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)	49,808,586	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,265,233	0	0	0	12.00
13.00	Land improvements	2,608,177	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	99,360,214	0	0	0	15.00
16.00	Accumulated depreciation	-69,353,014	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,085,819	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	37,638,987	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,726,634	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	76,332,050	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	97,884,836	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	2,327,641	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	100,212,477	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	226,353,113	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,484,516	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,803,034	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,564,626	0	0	0	43.00
44.00	Other current liabilities	1,951,893	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,804,069	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	59,359,052	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	17,539,599	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	76,898,651	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	92,702,720	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	133,650,393	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)	133,650,393	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	226,353,113	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/16/2020 2:07 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		133,050,086		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		804,775				2.00
3.00	Total (sum of line 1 and line 2)		133,854,861		0		3.00
4.00	CHANGE IN BENEFICIAL INTEREST IN PER	177,578		0		0	4.00
5.00	ROUNDING	6		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)		177,584		0		10.00
11.00	Subtotal (line 3 plus line 10)		134,032,445		0		11.00
12.00	CHANGE IN TEMPORARILY RESTRICTED NET	382,052		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)		382,052		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,650,393		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	CHANGE IN BENEFICIAL INTEREST IN PER		0				4.00
5.00	ROUNDING		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	CHANGE IN TEMPORARILY RESTRICTED NET		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: 14-0001

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/16/2020 2:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,838,398		12,838,398	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,427,260		1,427,260	7.00
8.00	NURSING FACILITY	962,557		962,557	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,228,215		15,228,215	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,722,112		2,722,112	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)	2,722,112		2,722,112	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,950,327		17,950,327	17.00
18.00	Ancillary services	40,707,319	125,760,825	166,468,144	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	19,092,003	19,092,003	20.00
20.01	ELMWOOD RHC	0	299,010	299,010	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DURABLE MEDICAL EQUIP - RENTED	0	4,814,875	4,814,875	27.00
27.01	PROFESSIONAL FEES	1,590,777	7,673,927	9,264,704	27.01
27.02	LAB GROSS UP	0	-334,317	-334,317	27.02
27.03	SCHOOL OF NURSING	0	263,547	263,547	27.03
27.04	DIETARY	0	596,360	596,360	27.04
27.05	ELMWOOD CLINIC NON-RHC	0	135,649	135,649	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	60,248,423	158,301,879	218,550,302	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,497,882		29.00
30.00	PROVISION FOR BAD DEBTS	8,935,650			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)		8,935,650		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)		97,433,532		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/16/2020 2:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	218,550,302	1.00
2.00	Less contractual allowances and discounts on patients' accounts	128,441,028	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,109,274	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,433,532	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,324,258	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,028,608	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	26,751	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	988,993	24.00
24.01	340B RETAIL PHARMACY	5,765,781	24.01
24.02	GAIN ON DISPOSAL	14,781	24.02
24.03	CARES ACT FUNDING	2,899,852	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	13,724,766	25.00
26.00	Total (line 5 plus line 25)	6,400,508	26.00
27.00	CHANGE IN FV OF INTEREST RATE SWAP	1,409,896	27.00
27.01	LOSS ON DISPOSAL	0	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	4,185,837	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	5,595,733	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	804,775	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0001	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/16/2020 2:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		473,383	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,895	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		18.69	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		480,278	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

11/16/2020 2:07 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	453,975	0	453,975	0	453,975
2.00	Physician Assistant	443,472	0	443,472	0	443,472
3.00	Nurse Practitioner	917,666	0	917,666	-75,757	841,909
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,700,387	0	1,700,387	-281,454	1,418,933
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	241,941	0	241,941	0	241,941
10.00	Subtotal (sum of lines 1 through 9)	3,757,441	0	3,757,441	-357,211	3,400,230
11.00	Physician Services Under Agreement	0	10,583,772	10,583,772	-289,318	10,294,454
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	10,583,772	10,583,772	-289,318	10,294,454
15.00	Medical Supplies	0	191,412	191,412	0	191,412
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	29,204	29,204	0	29,204
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	220,616	220,616	0	220,616
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,757,441	10,804,388	14,561,829	-646,529	13,915,300
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,311	1,311	0	1,311
30.00	Administrative Costs	1,363,492	90,247	1,453,739	-163,961	1,289,778
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,363,492	91,558	1,455,050	-163,961	1,291,089
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,120,933	10,895,946	16,016,879	-810,490	15,206,389

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/16/2020 2:07 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	453,975	1.00
2.00	Physician Assistant	0	443,472	2.00
3.00	Nurse Practitioner	0	841,909	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,418,933	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	241,941	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,400,230	10.00
11.00	Physician Services Under Agreement	0	10,294,454	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	10,294,454	14.00
15.00	Medical Supplies	0	191,412	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	29,204	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	220,616	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	13,915,300	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,311	29.00
30.00	Administrative Costs	-7,196	1,282,582	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,196	1,283,893	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-7,196	15,199,193	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-8603

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/16/2020 2:07 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	161,447	161,447
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	161,447	161,447
11.00	Physician Services Under Agreement	0	0	0	198,412	198,412
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	198,412	198,412
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	359,859	359,859
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	80,941	80,941
30.00	Administrative Costs	0	0	0	71,239	71,239
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	152,180	152,180
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	512,039	512,039

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-8603

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/16/2020 2:07 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	161,447	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	161,447	10.00
11.00	Physician Services Under Agreement	0	198,412	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	198,412	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	359,859	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	80,941	29.00
30.00	Administrative Costs	0	71,239	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	152,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	512,039	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001

Period:

Worksheet M-2

Component CCN: 14-3493

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/16/2020 2:07 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	16.68	61,615	4,200	70,056	1.00
2.00	Physician Assistant	2.85	7,617	2,100	5,985	2.00
3.00	Nurse Practitioner	7.18	20,745	2,100	15,078	3.00
4.00	Subtotal (sum of lines 1 through 3)	26.71	89,977		91,119	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	26.71	89,977		91,119	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)				13,915,300	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				13,915,300	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,283,893	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				8,083,335	15.00
16.00	Total overhead (sum of lines 14 and 15)				9,367,228	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				9,367,228	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				9,367,228	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				23,282,528	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001

Period:

Worksheet M-2

Component CCN: 14-8603

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/16/2020 2:07 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.29	1,625	4,200	1,218		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.13	1,008	2,100	273		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.42	2,633		1,491	2,633	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.42	2,633			2,633	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)					359,859	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					359,859	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					152,180	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					306,261	15.00
16.00	Total overhead (sum of lines 14 and 15)					458,441	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					458,441	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					458,441	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					818,300	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0001 Component CCN:14-3493	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/16/2020 2:07 pm		
			Title XVIII	RHC I	Cost	
					1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			23,282,528	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			601,788	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			22,680,740	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			91,119	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)			91,119	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			248.91	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)			84.70	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			248.91	248.91	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	17,461	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	4,346,218	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	4,346,218	16.00
16.01	Total program charges (see instructions)(from contractor's records)				2,554,955	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				115,649	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				196,732	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.)				3,130,259	16.04
16.05	Total program cost (see instructions)			0	3,326,991	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				236,662	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				440,493	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				3,326,991	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				141,923	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				3,468,914	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				3,468,914	26.00
26.01	Sequestration adjustment (see instructions)				57,931	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				2,888,214	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)				522,769	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0001 Component CCN:14-8603	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/16/2020 2:07 pm	
			Title XVIII	RHC II	Cost
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			818,300	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,593	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			814,707	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,633	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)			2,633	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			309.42	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)			84.70	8.00
9.00	Rate for Program covered visits (see instructions)			309.42	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)			0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	16.00
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				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.)				16.04
16.05	Total program cost (see instructions)			0	16.05
17.00	Primary payer amounts				17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			819	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			819	22.00
23.00	Allowable bad debts (see instructions)				23.00
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				25.50
25.99	Demonstration payment adjustment amount before sequestration				25.99
26.00	Net reimbursable amount (see instructions)			819	26.00
26.01	Sequestration adjustment (see instructions)			14	26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27.00	Interim payments				27.00
28.00	Tentative settlement (for contractor use only)				28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			805	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/16/2020 2:07 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,400,230	3,400,230	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000895	0.001911	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,043	6,498	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		297,637	52,495	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		300,680	58,993	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		13,915,300	13,915,300	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		9,367,228	9,367,228	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.021608	0.004239	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		202,407	39,708	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		503,087	98,701	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1,759	3,755	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		286.01	26.29	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		402	1,025	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		114,976	26,947	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)			601,788	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)			141,923	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-0001 Component CCN:14-8603	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/16/2020 2:07 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		161,447	161,447	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000013	0.000574	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2	93	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		283	1,202	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		285	1,295	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		359,859	359,859	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		458,441	458,441	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000792	0.003599	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		363	1,650	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		648	2,945	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1	86	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		648.00	34.24	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	5	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		648	171	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)			3,593	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)			819	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/16/2020 2:07 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,643,856	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01		02/13/2020	244,358	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		244,358	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,888,214	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		522,769	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,410,983	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101	8.00