

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/26/2021 7:53 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date: 1/26/2021 Time: 7:53 am
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 HARRISBURG MEDICAL CENTER, INC. (14-0210) 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) JUNE HAYES
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	199,276	-45,094	0	0	1.00
2.00	Subprovider - IPF	0	44,345	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	42	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		173,170		0	10.00
10.01	RURAL HEALTH CLINIC II	0		13,051		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-1,647		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		66,506		0	10.03
200.00	Total	0	243,663	205,986	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: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/26/2021 7:53 am			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 100 DR WARREN TUTTLE DRIVE			PO Box:							1.00	
2.00	City: HARRISBURG			State: IL		Zip Code: 62946		County: SALINE			2.00	
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
									V	XVIII	XIX	
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF			HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	N	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II			GALATIA PRIMARY CARE	148560	99914		05/10/2016	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III			HMC AT HARRISBURG	148589	99914		06/05/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV			HMC AT MARION	148590	99914		06/05/2018	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
								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.						3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/26/2021 7:53 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	15	105	0	0	323	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
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/26/2021 7:53 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000	64.00	

Worksheet S-2
Part I
Date/Time Prepared:
1/26/2021 7:53 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/26/2021 7:53 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/26/2021 7:53 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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:	278,571	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/26/2021 7:53 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:		Zip Code:				143.00		
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	N	161.00		
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00		
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
							Beginning	Ending		
							1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
							1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 1/26/2021 7:53 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	12/31/2018	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	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	12/16/2020	Y	12/16/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/26/2021 7:53 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/26/2021 7:53 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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						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)		38	13,908	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	30	10,980		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		68				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: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/26/2021 7:53 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,628	15	2,757			1.00
2.00	HMO and other (see instructions)	342	428				2.00
3.00	HMO IPF Subprovider	118	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	286	0	338			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	21			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,914	15	3,116			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,914	15	3,116	0.00	367.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,635	4,115	8,180	0.00	58.61	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,745	0	14,960	0.00	15.85	26.00
26.01	RURAL HEALTH CLINIC II	258	0	1,263	0.00	1.66	26.01
26.02	RURAL HEALTH CLINIC III	3,609	0	13,660	0.00	12.38	26.02
26.03	RURAL HEALTH CLINIC IV	3,889	0	15,208	0.00	15.70	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	471.60	27.00
28.00	Observation Bed Days		0	1,150			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/26/2021 7:53 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		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	611	151	1,043	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	611	151	1,043	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	258	548	1,015	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
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: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/26/2021 7:53 am

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	26,943,292	0	26,943,292	980,919.40	27.47
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		679,496	0	679,496	5,954.01	114.12
4.00	Physician-Part A - Administrative		40,000	0	40,000	325.00	123.08
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		5,790,319	0	5,790,319	48,462.28	119.48
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,250,428	-577	1,249,851	73,891.12	16.91
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,876,479	0	3,876,479	150,120.11	25.82
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		308,598	0	308,598	4,813.43	64.11
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		13,000	0	13,000	60.00	216.67
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,839,705	0	5,839,705		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,277,153	0	1,277,153		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		92,255	0	92,255		
22.00	Physician Part A - Administrative		5,178	0	5,178		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		763,572	0	763,572		
24.00	Wage-related costs (RHC/FQHC)		574,606	0	574,606		
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: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/26/2021 7:53 am

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	352,582	0	352,582	13,103.68	26.91	26.00
27.00	Administrative & General	5.00	3,567,249	0	3,567,249	143,201.83	24.91	27.00
28.00	Administrative & General under contract (see inst.)		246,771	0	246,771	1,362.85	181.07	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	446,064	0	446,064	25,961.15	17.18	30.00
31.00	Laundry & Linen Service	8.00	46,667	0	46,667	3,855.39	12.10	31.00
32.00	Housekeeping	9.00	508,137	0	508,137	41,769.19	12.17	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	562,282	0	562,282	39,726.77	14.15	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	80,674	0	80,674	5,572.50	14.48	38.00
39.00	Central Services and Supply	14.00	267,642	0	267,642	21,261.23	12.59	39.00
40.00	Pharmacy	15.00	524,641	0	524,641	11,095.27	47.29	40.00
41.00	Medical Records & Medical Records Library	16.00	514,033	0	514,033	26,645.56	19.29	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: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
1/26/2021 7:53 am

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	19,469,820	577	19,470,397	853,974.84	22.80	1.00
2.00	Excluded area salaries (see instructions)	3,876,479	0	3,876,479	150,120.11	25.82	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,593,341	577	15,593,918	703,854.73	22.16	3.00
4.00	Subtotal other wages & related costs (see inst.)	321,598	0	321,598	4,873.43	65.99	4.00
5.00	Subtotal wage-related costs (see inst.)	5,844,883	0	5,844,883	0.00	37.48	5.00
6.00	Total (sum of lines 3 thru 5)	21,759,822	577	21,760,399	708,728.16	30.70	6.00
7.00	Total overhead cost (see instructions)	7,116,742	0	7,116,742	333,555.42	21.34	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
1/26/2021 7:53 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	705,300	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	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	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)	5,649,164	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	75,329	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,004	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	233,350	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	1,445,027	17.00
18.00	Medicare Taxes - Employers Portion Only	337,950	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	47,347	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	21,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,552,471	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
1/26/2021 7:53 am

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	308,598	8,552,471	1.00
2.00	Hospital	308,598	7,052,644	2.00
3.00	Subprovider - IPF	0	840,239	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	232,174	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	17,932	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	209,291	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	200,191	14.03
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0210 Component CCN: 14-3473		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 1/26/2021 7:53 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1007 USE ROUTE 45		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ELDORADO IL 62930		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		08:00 20:00 08:00 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	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
		1.00	2.00	3.00	4.00
		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	SALINE		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	20:00	08:00	20:00	08:00
		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-3473

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

Date/Time Prepared:

1/26/2021 7:53 am

		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) CLINIC	08:00	16:50		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-8560		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 1/26/2021 7:53 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			124 E MAIN STREET			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			GALATIA IL 62935			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			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							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			SALINE				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8560

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

Date/Time Prepared:

1/26/2021 7:53 am

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-8589		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 1/26/2021 7:53 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				901 S COMMERCIAL		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				HARRISBURG		IL 62946		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				07:30		16:30		07:30
				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		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				SALINE				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				16:30		07:30		16:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8589

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

		RHC III		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1)				
	CLINIC	07:30	16:30	09:00	13:00
					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-8590		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 1/26/2021 7:53 am	
				RHC IV		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				3106 OUTER DRIVE				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				MARION		IL 62959		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				07:30		16:30		11.00
						1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?								12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								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				WILLIAMSON				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				16:30		07:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8590

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

Date/Time Prepared:

1/26/2021 7:53 am

RHC IV

Cost

		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)							
	CLINIC	07:30	16:30				11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 1/26/2021 7:53 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.348784 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	7,736,863		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,250,250		5.00
6.00	Medicaid charges	27,590,548		6.00
7.00	Medicaid cost (line 1 times line 6)	9,623,142		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)	636,029		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	4,281		9.00
10.00	Stand-alone CHIP charges	28,535		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	9,953		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	5,672		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)	641,701		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)	924,404	992,172	1,916,576 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	322,417	992,172	1,314,589 21.00
22.00	Payments received from patients for amounts previously written off as charity care	33	14,505	14,538 22.00
23.00	Cost of charity care (line 21 minus line 22)	322,384	977,667	1,300,051 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,668,651		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	529,842		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	815,141		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,853,510		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	931,774		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,231,825		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,873,526		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:
1/26/2021 7:53 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,806,068	2,806,068	-198,378	2,607,690	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,402,024	1,402,024	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	352,582	8,687,574	9,040,156	0	9,040,156	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,567,249	3,991,038	7,558,287	-72,320	7,485,967	5.00
7.00	00700	OPERATION OF PLANT	446,064	739,537	1,185,601	65,554	1,251,155	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,667	72,838	119,505	0	119,505	8.00
9.00	00900	HOUSEKEEPING	508,137	78,433	586,570	0	586,570	9.00
10.00	01000	DIETARY	562,282	286,956	849,238	0	849,238	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	80,674	2,561	83,235	0	83,235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	267,642	129,087	396,729	0	396,729	14.00
15.00	01500	PHARMACY	524,641	515,809	1,040,450	0	1,040,450	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	514,033	313,547	827,580	0	827,580	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	679,496	679,496	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,203,124	672,463	4,875,587	0	4,875,587	30.00
40.00	04000	SUBPROVIDER - IPF	2,550,718	1,132,204	3,682,922	0	3,682,922	40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	611,520	324,889	936,409	0	936,409	50.00
53.00	05300	ANESTHESIOLOGY	949,678	38,827	988,505	-679,496	309,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,809	188,233	759,042	577	759,619	54.00
54.01	05401	ULTRASOUND	187,931	27,239	215,170	0	215,170	54.01
54.02	03440	MAMMOGRAPHY	69,852	64,658	134,510	0	134,510	54.02
56.00	05600	RADIOISOTOPE	125,894	240,705	366,599	0	366,599	56.00
57.00	05700	CT SCAN	193,962	136,586	330,548	0	330,548	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,893	212,555	279,448	0	279,448	58.00
60.00	06000	LABORATORY	791,727	1,393,130	2,184,857	0	2,184,857	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	536,625	180,478	717,103	0	717,103	65.00
66.00	06600	PHYSICAL THERAPY	600,953	13,536	614,489	0	614,489	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,450	7,118	167,568	0	167,568	67.00
68.00	06800	SPEECH PATHOLOGY	26,437	0	26,437	0	26,437	68.00
69.00	06900	ELECTROCARDIOLOGY	82,693	78,270	160,963	0	160,963	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,511,856	1,511,856	-1,266,753	245,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,266,753	1,266,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,392,149	1,392,149	0	1,392,149	73.00
75.00	07500	ASC (NON-DISTINCT PART)	566,937	91,267	658,204	0	658,204	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	111,266	4,898	116,164	0	116,164	76.00
76.97	07697	CARDIAC REHABILITATION	85,253	23,155	108,408	0	108,408	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,222,218	491,906	1,714,124	-39,335	1,674,789	88.00
88.01	08801	RURAL HEALTH CLINIC II	94,756	43,429	138,185	-14,017	124,168	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,101,477	564,739	1,666,216	-17,906	1,648,310	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,053,750	1,163,087	2,216,837	-192,588	2,024,249	88.03
91.00	09100	EMERGENCY	2,782,637	933,025	3,715,662	0	3,715,662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	884	884	-884	0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		910,373	910,373	-910,373	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,617,531	29,465,107	55,082,638	22,354	55,104,992	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,226,351	194,190	1,420,541	-13,554	1,406,987	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	41,310	523	41,833	0	41,833	194.01
194.02	07952	FOUNDATION	58,100	93,003	151,103	-8,800	142,303	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	26,943,292	29,752,823	56,696,115	0	56,696,115	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-132,164	2,475,526	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,402,024	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,361,656	7,678,500	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-326,989	7,158,978	5.00
7.00	00700	OPERATION OF PLANT	35	1,251,190	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,505	8.00
9.00	00900	HOUSEKEEPING	0	586,570	9.00
10.00	01000	DIETARY	-97,720	751,518	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	83,235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	396,729	14.00
15.00	01500	PHARMACY	-485,499	554,951	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28,760	798,820	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-679,496	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,081,728	2,793,859	30.00
40.00	04000	SUBPROVIDER - IPF	-499,536	3,183,386	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-10,973	925,436	50.00
53.00	05300	ANESTHESIOLOGY	-270,182	38,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	759,619	54.00
54.01	05401	ULTRASOUND	0	215,170	54.01
54.02	03440	MAMMOGRAPHY	0	134,510	54.02
56.00	05600	RADIOISOTOPE	0	366,599	56.00
57.00	05700	CT SCAN	14	330,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	279,448	58.00
60.00	06000	LABORATORY	-6,867	2,177,990	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-40,612	676,491	65.00
66.00	06600	PHYSICAL THERAPY	-81	614,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	167,568	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,437	68.00
69.00	06900	ELECTROCARDIOLOGY	-43,518	117,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	245,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,266,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,392,149	73.00
75.00	07500	ASC (NON-DISTINCT PART)	103	658,307	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	116,164	76.00
76.97	07697	CARDIAC REHABILITATION	-19,561	88,847	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,674,789	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	124,168	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,648,310	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,024,249	88.03
91.00	09100	EMERGENCY	-2,340,369	1,375,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,425,559	46,679,433	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,406,987	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	194.00
194.01	07951	AUXILIARY	0	41,833	194.01
194.02	07952	FOUNDATION	0	142,303	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,425,559	48,270,556	200.00

RECLASSIFICATIONS

Provider CCN: 14-0210

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

Worksheet A-6

Date/Time Prepared:
1/26/2021 7:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXP & BOND AMORT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	910,373		1.00
	0		0	910,373		
	B - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,367,852		1.00
	0		0	1,367,852		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	111,060		1.00
	0		0	111,060		
	G - RADIOLOGY TECHS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	577	0		1.00
	0		577	0		
	I - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,266,753		1.00
	0		0	1,266,753		
	J - CRNA SALARIES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	679,496	0		1.00
	0		679,496	0		
	L - ALLOWABLE ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,800		1.00
	0		0	8,800		
	M - OVERHEAD COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,213		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	37,516		2.00
3.00	OPERATION OF PLANT	7.00	0	65,554		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
	0		0	285,283		
	N - TERMINATED SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	884		1.00
	TOTALS		0	884		
500.00	Grand Total: Increases		680,073	3,951,005		500.00

RECLASSIFICATIONS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/26/2021 7:53 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	A - INTEREST EXP & BOND AMORT					
1.00	INTEREST EXPENSE	113.00	0	910,373	11	1.00
	0		0	910,373		
	B - MME DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,367,852	9	1.00
	0		0	1,367,852		
	D - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	111,060	12	1.00
	0		0	111,060		
	G - RADIOLOGY TECHS					
1.00	RURAL HEALTH CLINIC	88.00	577	0	0	1.00
	0		577	0		
	I - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,266,753	0	1.00
	0		0	1,266,753		
	J - CRNA SALARIES					
1.00	ANESTHESIOLOGY	53.00	679,496	0	0	1.00
	0		679,496	0		
	L - ALLOWABLE ADVERTISING					
1.00	FOUNDATION	194.02	0	8,800	0	1.00
	0		0	8,800		
	M - OVERHEAD COSTS					
1.00	RURAL HEALTH CLINIC	88.00	0	38,758	10	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	14,017	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	17,906	0	3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	192,588	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,554	0	5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	8,460	0	6.00
	0		0	285,283		
	N - TERMINATED SERVICES					
1.00	HOME HEALTH AGENCY	101.00	0	884	0	1.00
	TOTALS		0	884		
500.00	Grand Total: Decreases		680,073	3,951,005		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/26/2021 7:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	839,600	0	0	0	67,157	1.00	
2.00	Land Improvements	893,892	5,665	0	5,665	210,703	2.00	
3.00	Buildings and Fixtures	37,372,745	996,295	0	996,295	64,045	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	17,569,882	1,649,572	0	1,649,572	532,999	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	56,676,119	2,651,532	0	2,651,532	874,904	8.00	
9.00	Reconciling Items	-258,543	-2,428,258	0	-2,428,258	0	9.00	
10.00	Total (line 8 minus line 9)	56,934,662	5,079,790	0	5,079,790	874,904	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	772,443	0					1.00
2.00	Land Improvements	688,854	0					
3.00	Buildings and Fixtures	38,304,995	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	18,686,455	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	58,452,747	0					
9.00	Reconciling Items	-2,686,801	0					
10.00	Total (line 8 minus line 9)	61,139,548	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,806,068	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)	2,806,068	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	2,806,068				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,806,068				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	39,766,292	0	39,766,292	0.692311	76,888	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	18,686,455	1,012,785	17,673,670	0.307689	34,172	2.00	
3.00	Total (sum of lines 1-2)	58,452,747	1,012,785	57,439,962	1.000000	111,060	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	76,888	1,438,216	182,213	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	34,172	1,367,852	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	111,060	2,806,068	182,213	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	778,209	76,888	0	0	2,475,526	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	34,172	0	0	1,402,024	2.00	
3.00	Total (sum of lines 1-2)	778,209	111,060	0	0	3,877,550	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-132,164	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	-186	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,743	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,313,537			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	-97,720	DIETARY	10.00	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	-28,760	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-5,354	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-679,496	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-133,656	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
1/26/2021 7:53 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 CREDENTIALLING INCOME	B	-2,675	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MISC INCOME - LAB	B	-1,376	LABORATORY	60.00	0	33.02
34.00 RENTAL INCOME	A	-13,000	ADMINISTRATIVE & GENERAL	5.00	0	34.00
37.00 CRNA BENEFITS	A	-215,689	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01 PHYSICIAN BENEFITS	A	-1,145,442	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.01
37.02 CAPITALIZED INTEREST	A		35 OPERATION OF PLANT	7.00	0	37.02
37.03 CAPITALIZED INTEREST	A	77	OPERATING ROOM	50.00	0	37.03
37.04 CAPITALIZED INTEREST	A	14	CT SCAN	57.00	0	37.04
37.05 CAPITALIZED INTEREST	A	152	PHYSICAL THERAPY	66.00	0	37.05
38.00 CAPITALIZED INTEREST	A	103	ASC (NON-DISTINCT PART)	75.00	0	38.00
38.01 CAPITALIZED INTEREST	A	90	EMERGENCY	91.00	0	38.01
38.02 340B RETAIL PHARMACY	A	-485,499	PHARMACY	15.00	0	38.02
38.03 COMM RELATIONS - PT	A	-233	PHYSICAL THERAPY	66.00	0	38.03
39.00 COMM RELATIONS - A&G	A	-14,544	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01 INSURANCE SETTLEMENTS	A	-1,378	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02 PHYSICIAN RECRUITMENT	A	-2,092	ADMINISTRATIVE & GENERAL	5.00	0	39.02
40.00 PHYSICIAN LOANS	A	-120,000	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01 ALCOHOL	A	-43	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02 LOBBYING DUES	A	-18,470	ADMINISTRATIVE & GENERAL	5.00	0	40.02
40.03 HR DUES	A	-525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04 ADMIN DUES	A	-3,753	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05 BOARD MEMBER EXPENSE	A	-1,695	ADMINISTRATIVE & GENERAL	5.00	0	40.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,425,559				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0210

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2021 7:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,400	1,400	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,081,728	2,081,728	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	555,931	405,139	150,792	181,300	647	3.00
4.00	50.00	OPERATING ROOM	11,050	11,050	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	270,182	270,182	0	0	0	5.00
6.00	60.00	LABORATORY	13,000	0	13,000	260,300	60	6.00
7.00	65.00	RESPIRATORY THERAPY	40,612	40,612	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	43,518	43,518	0	0	0	8.00
9.00	76.97	CARDIAC REHABILITATION	19,561	19,561	0	0	0	9.00
10.00	91.00	EMERGENCY	2,373,538	2,333,538	40,000	211,500	325	10.00
200.00			5,410,520	5,206,728	203,792		1,032	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	10,282	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	56,395	2,820	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	7,509	375	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	33,047	1,652	1,891	32	0	10.00
200.00			96,951	4,847	12,173	32	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,400		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,081,728		2.00
3.00	40.00	SUBPROVIDER - IPF	0	56,395	94,397	499,536		3.00
4.00	50.00	OPERATING ROOM	0	0	0	11,050		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	270,182		5.00
6.00	60.00	LABORATORY	0	7,509	5,491	5,491		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	40,612		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	43,518		8.00
9.00	76.97	CARDIAC REHABILITATION	0	0	0	19,561		9.00
10.00	91.00	EMERGENCY	0	33,079	6,921	2,340,459		10.00
200.00			0	96,983	106,809	5,313,537		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,475,526	2,475,526			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,402,024		1,402,024		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,678,500	33,395	2,674	7,714,569	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,158,978	270,869	300,315	1,233,934	5.00
7.00	00700	OPERATION OF PLANT	1,251,190	54,166	8,845	154,295	1,468,496
8.00	00800	LAUNDRY & LINEN SERVICE	119,505	3,919	6,419	16,142	145,985
9.00	00900	HOUSEKEEPING	586,570	9,798	1,171	175,766	773,305
10.00	01000	DIETARY	751,518	47,978	7,243	194,495	1,001,234
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	83,235	10,891	137	27,905	122,168
14.00	01400	CENTRAL SERVICES & SUPPLY	396,729	105,753	17,624	92,578	612,684
15.00	01500	PHARMACY	554,951	17,244	33,803	181,475	787,473
16.00	01600	MEDICAL RECORDS & LIBRARY	798,820	13,593	1,613	177,806	991,832
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,793,859	194,055	95,321	853,000	3,936,235
40.00	04000	SUBPROVIDER - IPF	3,183,386	298,464	13,265	882,301	4,377,416
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	925,436	143,912	202,716	211,527	1,483,591
53.00	05300	ANESTHESIOLOGY	38,827	0	12,444	0	51,271
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,619	44,842	129,192	197,644	1,131,297
54.01	05401	ULTRASOUND	215,170	10,293	55,778	65,006	346,247
54.02	03440	MAMMOGRAPHY	134,510	6,353	29,208	24,162	194,233
56.00	05600	RADIOISOTOPE	366,599	38,531	16,271	43,547	464,948
57.00	05700	CT SCAN	330,562	10,850	111,843	67,092	520,347
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	279,448	0	437	23,138	303,023
60.00	06000	LABORATORY	2,177,990	59,281	128,548	273,861	2,639,680
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	676,491	27,330	12,160	185,620	901,601
66.00	06600	PHYSICAL THERAPY	614,408	68,955	7,881	207,871	899,115
67.00	06700	OCCUPATIONAL THERAPY	167,568	3,960	0	55,500	227,028
68.00	06800	SPEECH PATHOLOGY	26,437	0	0	9,145	35,582
69.00	06900	ELECTROCARDIOLOGY	117,445	33,910	3,781	28,604	183,740
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	245,103	0	0	0	245,103
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,266,753	0	0	0	1,266,753
73.00	07300	DRUGS CHARGED TO PATIENTS	1,392,149	0	0	0	1,392,149
75.00	07500	ASC (NON-DISTINCT PART)	658,307	113,550	54,453	196,105	1,022,415
76.00	03950	FAITH CENTER CHEMOTHERAPY	116,164	23,040	10,839	38,487	188,530
76.97	07697	CARDIAC REHABILITATION	88,847	0	2,562	29,489	120,898
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,674,789	241,311	10,260	422,569	2,348,929
88.01	08801	RURAL HEALTH CLINIC II	124,168	18,523	3,662	32,776	179,129
88.02	08802	RURAL HEALTH CLINIC III	1,648,310	134,878	23,217	381,004	2,187,409
88.03	08803	RURAL HEALTH CLINIC IV	2,024,249	198,779	15,567	364,495	2,603,090
91.00	09100	EMERGENCY	1,375,293	134,857	47,719	408,646	1,966,515
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,679,433	2,373,280	1,366,968	7,255,985	46,083,547
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,406,987	83,043	33,918	424,198	1,948,146
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0
194.01	07951	AUXILIARY	41,833	14,253	0	14,289	70,375
194.02	07952	FOUNDATION	142,303	4,950	1,138	20,097	168,488
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	48,270,556	2,475,526	1,402,024	7,714,569	48,270,556

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/26/2021 7:53 am

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	8,964,096					5.00
7.00	00700	OPERATION OF PLANT	334,901	1,803,397				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,293	3,338	182,616			8.00
9.00	00900	HOUSEKEEPING	176,358	8,346	0	958,009		9.00
10.00	01000	DIETARY	228,338	40,868	0	0	1,270,440	10.00
11.00	01100	CAFETERIA	0	0	0	0	336,163	11.00
13.00	01300	NURSING ADMINISTRATION	27,861	9,277	0	18,163	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,727	90,083	0	0	0	14.00
15.00	01500	PHARMACY	179,589	14,689	0	10,560	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226,194	11,579	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	897,686	165,301	55,466	259,356	500,537	30.00
40.00	04000	SUBPROVIDER - IPF	998,281	254,242	20,964	143,194	312,588	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	338,343	122,588	15,271	54,912	0	50.00
53.00	05300	ANESTHESIOLOGY	11,693	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,000	38,198	12,617	0	0	54.00
54.01	05401	ULTRASOUND	78,964	8,768	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	44,296	5,412	0	0	0	54.02
56.00	05600	RADIOISOTOPE	106,035	32,821	0	0	0	56.00
57.00	05700	CT SCAN	118,669	9,242	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69,107	0	0	0	0	58.00
60.00	06000	LABORATORY	601,998	50,497	0	23,232	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	205,616	23,281	6,443	19,431	0	65.00
66.00	06600	PHYSICAL THERAPY	205,049	58,737	5,347	17,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,775	3,373	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,115	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,903	28,886	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,897	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	288,892	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,489	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	233,169	96,724	18,079	68,852	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	42,996	19,626	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	27,572	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	535,690	205,555	17,194	67,584	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	40,852	15,778	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	498,854	114,892	12,771	57,869	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	593,653	169,325	6,001	27,456	0	88.03
91.00	09100	EMERGENCY	448,478	114,875	12,463	190,081	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,465,333	1,716,301	182,616	958,009	1,149,288	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	444,288	70,738	0	0	121,152	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	16,050	12,141	0	0	0	194.01
194.02	07952	FOUNDATION	38,425	4,217	0	0	0	194.02
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)	8,964,096	1,803,397	182,616	958,009	1,270,440	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	336,163					11.00
13.00	01300	NURSING ADMINISTRATION	3,227	180,696				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,312	0	854,806			14.00
15.00	01500	PHARMACY	6,425	0	0	998,736		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,430	0	3,045	0	1,248,080	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,094	51,689	169,048	0	72,506	30.00
40.00	04000	SUBPROVIDER - IPF	70,593	58,763	44,573	0	106,415	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,837	20,675	244,244	0	53,487	50.00
53.00	05300	ANESTHESIOLOGY	0	0	4,270	0	31,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,380	0	3,271	0	46,762	54.00
54.01	05401	ULTRASOUND	6,257	0	14,678	0	41,180	54.01
54.02	03440	MAMMOGRAPHY	1,543	0	435	0	4,935	54.02
56.00	05600	RADIOISOTOPE	4,358	0	4,755	0	29,977	56.00
57.00	05700	CT SCAN	4,702	0	8,936	0	171,760	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,353	0	0	0	30,852	58.00
60.00	06000	LABORATORY	21,104	0	30,979	0	171,712	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,186	0	0	0	37,017	65.00
66.00	06600	PHYSICAL THERAPY	10,390	0	2,022	0	25,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,764	0	0	0	10,240	67.00
68.00	06800	SPEECH PATHOLOGY	240	0	0	0	820	68.00
69.00	06900	ELECTROCARDIOLOGY	2,059	0	3,870	0	19,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	21,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,776	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	831,236	93,015	73.00
75.00	07500	ASC (NON-DISTINCT PART)	19,833	16,509	86,056	0	41,964	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,082	1,733	11,821	0	4,181	76.00
76.97	07697	CARDIAC REHABILITATION	1,720	1,432	3,055	0	4,035	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	11,284	17,716	24,038	24,547	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	435	4,406	2,314	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	20,935	55,135	29,487	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	21,499	67,667	33,586	88.03
91.00	09100	EMERGENCY	22,357	18,611	148,934	0	124,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322,246	180,696	844,577	982,482	1,248,080	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,197	0	8,772	16,254	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,440	0	184	0	0	194.01
194.02	07952	FOUNDATION	2,280	0	1,273	0	0	194.02
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)	336,163	180,696	854,806	998,736	1,248,080	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,169,918	-520,268	5,649,650	30.00
40.00	04000	SUBPROVIDER - IPF	0	6,387,029	0	6,387,029	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,357,948	0	2,357,948	50.00
53.00	05300	ANESTHESIOLOGY	0	99,022	0	99,022	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,504,525	0	1,504,525	54.00
54.01	05401	ULTRASOUND	0	496,094	0	496,094	54.01
54.02	03440	MAMMOGRAPHY	0	250,854	0	250,854	54.02
56.00	05600	RADIOISOTOPE	0	642,894	0	642,894	56.00
57.00	05700	CT SCAN	0	833,656	0	833,656	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	404,335	0	404,335	58.00
60.00	06000	LABORATORY	0	3,539,202	0	3,539,202	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	520,268	520,268	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,205,575	0	1,205,575	65.00
66.00	06600	PHYSICAL THERAPY	0	1,223,783	0	1,223,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	295,180	0	295,180	67.00
68.00	06800	SPEECH PATHOLOGY	0	44,757	0	44,757	68.00
69.00	06900	ELECTROCARDIOLOGY	0	280,210	0	280,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	322,817	0	322,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,569,421	0	1,569,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,633,889	0	2,633,889	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,603,601	0	1,603,601	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	270,969	0	270,969	76.00
76.97	07697	CARDIAC REHABILITATION	0	158,712	0	158,712	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,252,537	0	3,252,537	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	242,914	0	242,914	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,977,352	0	2,977,352	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,522,277	0	3,522,277	88.03
91.00	09100	EMERGENCY	0	3,046,665	0	3,046,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	45,336,136	0	45,336,136	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,619,547	0	2,619,547	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	100,190	0	100,190	194.01
194.02	07952	FOUNDATION	0	214,683	0	214,683	194.02
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)	0	48,270,556	0	48,270,556	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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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	33,395	2,674	36,069	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,429	270,869	300,315	576,613	5.00
7.00	00700	OPERATION OF PLANT	2,454	54,166	8,845	65,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,919	6,419	10,338	8.00
9.00	00900	HOUSEKEEPING	0	9,798	1,171	10,969	9.00
10.00	01000	DIETARY	0	47,978	7,243	55,221	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,891	137	11,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,012	105,753	17,624	126,389	14.00
15.00	01500	PHARMACY	0	17,244	33,803	51,047	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,593	1,613	15,206	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,061	194,055	95,321	292,437	30.00
40.00	04000	SUBPROVIDER - IPF	0	298,464	13,265	311,729	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,582	143,912	202,716	515,210	50.00
53.00	05300	ANESTHESIOLOGY	10,515	0	12,444	22,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,842	129,192	174,034	54.00
54.01	05401	ULTRASOUND	0	10,293	55,778	66,071	54.01
54.02	05402	MAMMOGRAPHY	0	6,353	29,208	35,561	54.02
56.00	05600	RADIOISOTOPE	0	38,531	16,271	54,802	56.00
57.00	05700	CT SCAN	0	10,850	111,843	122,693	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	210,000	0	437	210,437	58.00
60.00	06000	LABORATORY	0	59,281	128,548	187,829	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,804	27,330	12,160	67,294	65.00
66.00	06600	PHYSICAL THERAPY	0	68,955	7,881	76,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,960	0	3,960	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	29,900	33,910	3,781	67,591	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	113,550	54,453	168,003	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	23,040	10,839	33,879	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	2,562	2,562	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,633	241,311	10,260	253,204	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	18,523	3,662	22,185	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	134,878	23,217	158,095	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	198,779	15,567	214,346	88.03
91.00	09100	EMERGENCY	0	134,857	47,719	182,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	462,390	2,373,280	1,366,968	4,202,638	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,391	83,043	33,918	126,352	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	14,253	0	14,253	194.01
194.02	07952	FOUNDATION	0	4,950	1,138	6,088	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	471,781	2,475,526	1,402,024	4,349,331	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/26/2021 7:53 am

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	582,386					5.00
7.00	00700	OPERATION OF PLANT	21,759	87,945				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,163	163	12,739			8.00
9.00	00900	HOUSEKEEPING	11,458	407	0	23,656		9.00
10.00	01000	DIETARY	14,835	1,993	0	0	72,958	10.00
11.00	01100	CAFETERIA	0	0	0	0	19,305	11.00
13.00	01300	NURSING ADMINISTRATION	1,810	452	0	449	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,078	4,393	0	0	0	14.00
15.00	01500	PHARMACY	11,668	716	0	261	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,696	565	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,323	8,061	3,871	6,402	28,745	30.00
40.00	04000	SUBPROVIDER - IPF	64,846	12,397	1,462	3,536	17,951	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,982	5,978	1,065	1,356	0	50.00
53.00	05300	ANESTHESIOLOGY	760	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,762	1,863	880	0	0	54.00
54.01	05401	ULTRASOUND	5,130	428	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	2,878	264	0	0	0	54.02
56.00	05600	RADIOISOTOPE	6,889	1,601	0	0	0	56.00
57.00	05700	CT SCAN	7,710	451	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,490	0	0	0	0	58.00
60.00	06000	LABORATORY	39,112	2,463	0	574	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,359	1,135	449	480	0	65.00
66.00	06600	PHYSICAL THERAPY	13,322	2,864	373	428	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,364	165	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	527	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,722	1,409	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,632	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,769	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,627	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,149	4,717	1,261	1,700	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,793	957	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,791	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34,804	10,024	1,199	1,669	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,654	769	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	32,411	5,603	891	1,429	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	38,570	8,257	419	678	0	88.03
91.00	09100	EMERGENCY	29,138	5,602	869	4,694	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	549,981	83,697	12,739	23,656	66,001	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,866	3,450	0	0	6,957	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,043	592	0	0	0	194.01
194.02	07952	FOUNDATION	2,496	206	0	0	0	194.02
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)	582,386	87,945	12,739	23,656	72,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	19,305					11.00
13.00	01300	NURSING ADMINISTRATION	185	14,054				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	707	0	141,000			14.00
15.00	01500	PHARMACY	369	0	0	64,909		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	886	0	502	0	32,686	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,566	4,020	27,884	0	1,895	30.00
40.00	04000	SUBPROVIDER - IPF	4,052	4,571	7,352	0	2,782	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,426	1,608	40,289	0	1,398	50.00
53.00	05300	ANESTHESIOLOGY	0	0	704	0	831	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	826	0	540	0	1,222	54.00
54.01	05401	ULTRASOUND	359	0	2,421	0	1,076	54.01
54.02	03440	MAMMOGRAPHY	89	0	72	0	129	54.02
56.00	05600	RADIOISOTOPE	250	0	784	0	784	56.00
57.00	05700	CT SCAN	270	0	1,474	0	4,552	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	78	0	0	0	806	58.00
60.00	06000	LABORATORY	1,212	0	5,110	0	4,489	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	0	0	0	968	65.00
66.00	06600	PHYSICAL THERAPY	597	0	334	0	675	66.00
67.00	06700	OCCUPATIONAL THERAPY	159	0	0	0	268	67.00
68.00	06800	SPEECH PATHOLOGY	14	0	0	0	21	68.00
69.00	06900	ELECTROCARDIOLOGY	118	0	638	0	516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	360	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,024	2,431	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,139	1,284	14,195	0	1,097	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	120	135	1,950	0	109	76.00
76.97	07697	CARDIAC REHABILITATION	99	111	504	0	105	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	878	2,922	1,562	642	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	72	286	60	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	3,453	3,583	771	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	3,546	4,398	878	88.03
91.00	09100	EMERGENCY	1,284	1,447	24,567	0	3,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,505	14,054	139,313	63,853	32,686	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	586	0	1,447	1,056	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	83	0	30	0	0	194.01
194.02	07952	FOUNDATION	131	0	210	0	0	194.02
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)	19,305	14,054	141,000	64,909	32,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		439,192	0	439,192	30.00
40.00	04000	SUBPROVIDER - IPF		434,803	0	434,803	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		591,301	0	591,301	50.00
53.00	05300	ANESTHESIOLOGY		25,254	0	25,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		197,051	0	197,051	54.00
54.01	05401	ULTRASOUND		75,789	0	75,789	54.01
54.02	03440	MAMMOGRAPHY		39,106	0	39,106	54.02
56.00	05600	RADIOISOTOPE		65,314	0	65,314	56.00
57.00	05700	CT SCAN		137,464	0	137,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		215,919	0	215,919	58.00
60.00	06000	LABORATORY		242,069	0	242,069	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		85,253	0	85,253	65.00
66.00	06600	PHYSICAL THERAPY		96,401	0	96,401	66.00
67.00	06700	OCCUPATIONAL THERAPY		8,175	0	8,175	67.00
68.00	06800	SPEECH PATHOLOGY		605	0	605	68.00
69.00	06900	ELECTROCARDIOLOGY		73,128	0	73,128	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		4,202	0	4,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		19,129	0	19,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		77,082	0	77,082	73.00
75.00	07500	ASC (NON-DISTINCT PART)		209,462	0	209,462	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		40,123	0	40,123	76.00
76.97	07697	CARDIAC REHABILITATION		5,310	0	5,310	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		308,879	0	308,879	88.00
88.01	08801	RURAL HEALTH CLINIC II		26,179	0	26,179	88.01
88.02	08802	RURAL HEALTH CLINIC III		208,017	0	208,017	88.02
88.03	08803	RURAL HEALTH CLINIC IV		272,796	0	272,796	88.03
91.00	09100	EMERGENCY		255,338	0	255,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,153,341	0	4,153,341	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES		170,697	0	170,697	192.00
194.00	07950	RETAIL 340B PHARMACY		0	0	0	194.00
194.01	07951	AUXILIARY		16,068	0	16,068	194.01
194.02	07952	FOUNDATION		9,225	0	9,225	194.02
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)	0	4,349,331	0	4,349,331	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	120,016					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,367,852				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,619	2,609	22,302,668			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,132	292,994	3,567,249	-8,964,096	39,306,460	5.00
7.00	00700	OPERATION OF PLANT	2,626	8,629	446,064	0	1,468,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	6,263	46,667	0	145,985	8.00
9.00	00900	HOUSEKEEPING	475	1,142	508,137	0	773,305	9.00
10.00	01000	DIETARY	2,326	7,066	562,282	0	1,001,234	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	528	134	80,674	0	122,168	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	17,194	267,642	0	612,684	14.00
15.00	01500	PHARMACY	836	32,979	524,641	0	787,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	1,574	514,033	0	991,832	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,408	92,998	2,466,008	0	3,936,235	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	12,942	2,550,718	0	4,377,416	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,977	197,775	611,520	0	1,483,591	50.00
53.00	05300	ANESTHESIOLOGY	0	12,141	0	0	51,271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	126,043	571,386	0	1,131,297	54.00
54.01	05401	ULTRASOUND	499	54,419	187,931	0	346,247	54.01
54.02	03440	MAMMOGRAPHY	308	28,496	69,852	0	194,233	54.02
56.00	05600	RADIOISOTOPE	1,868	15,874	125,894	0	464,948	56.00
57.00	05700	CT SCAN	526	109,117	193,962	0	520,347	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	426	66,893	0	303,023	58.00
60.00	06000	LABORATORY	2,874	125,415	791,727	0	2,639,680	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	11,864	536,625	0	901,601	65.00
66.00	06600	PHYSICAL THERAPY	3,343	7,689	600,953	0	899,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	160,450	0	227,028	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	26,437	0	35,582	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	3,689	82,693	0	183,740	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	245,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,266,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,392,149	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	53,126	566,937	0	1,022,415	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	10,575	111,266	0	188,530	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,500	85,253	0	120,898	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,699	10,010	1,221,641	0	2,348,929	88.00
88.01	08801	RURAL HEALTH CLINIC II	898	3,573	94,756	0	179,129	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,539	22,651	1,101,477	0	2,187,409	88.02
88.03	08803	RURAL HEALTH CLINIC IV	9,637	15,188	1,053,750	0	2,603,090	88.03
91.00	09100	EMERGENCY	6,538	46,556	1,181,389	0	1,966,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,059	1,333,651	20,976,907	-8,964,096	37,119,451	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	33,091	1,226,351	0	1,948,146	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	41,310	0	70,375	194.01
194.02	07952	FOUNDATION	240	1,110	58,100	0	168,488	194.02
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)	2,475,526	1,402,024	7,714,569		8,964,096	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.626633	1.024982	0.345903		0.228057	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,069		582,386	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001617		0.014817	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
		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	102,639				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	47,475			8.00
9.00	00900	HOUSEKEEPING	475	0	2,268		9.00
10.00	01000	DIETARY	2,326	0	0	196,377	10.00
11.00	01100	CAFETERIA	0	0	0	51,962	11.00
13.00	01300	NURSING ADMINISTRATION	528	0	43	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	0	0	0	14.00
15.00	01500	PHARMACY	836	0	25	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,408	14,420	614	77,370	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	5,450	339	48,318	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,977	3,970	130	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	3,280	0	0	54.00
54.01	05401	ULTRASOUND	499	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	308	0	0	0	54.02
56.00	05600	RADIOISOTOPE	1,868	0	0	0	56.00
57.00	05700	CT SCAN	526	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	2,874	0	55	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	1,675	46	0	65.00
66.00	06600	PHYSICAL THERAPY	3,343	1,390	41	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	5,505	4,700	163	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,699	4,470	160	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	898	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,539	3,320	137	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	9,637	1,560	65	0	88.03
91.00	09100	EMERGENCY	6,538	3,240	450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				38,607	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,682	47,475	2,268	177,650	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	0	0	18,727	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	0	0	194.01
194.02	07952	FOUNDATION	240	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,803,397	182,616	958,009	1,270,440	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.570290	3.846572	422.402557	6.469393	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,945	12,739	23,656	72,958	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.856838	0.268331	10.430335	0.371520	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: 14-0210

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

Worksheet B-1

Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	374,849					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	465,388				14.00
15.00	01500	PHARMACY	0	0	1,672,676			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,658	0	129,983,475		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	107,228	92,036	0	7,551,184	0	30.00
40.00	04000	SUBPROVIDER - IPF	121,900	24,267	0	11,082,537	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,890	132,975	0	5,570,419	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,325	0	3,310,559	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,781	0	4,869,993	0	54.00
54.01	05401	ULTRASOUND	0	7,991	0	4,288,724	0	54.01
54.02	03440	MAMMOGRAPHY	0	237	0	513,960	0	54.02
56.00	05600	RADIOISOTOPE	0	2,589	0	3,121,923	0	56.00
57.00	05700	CT SCAN	0	4,865	0	17,890,393	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,213,073	0	58.00
60.00	06000	LABORATORY	0	16,866	0	17,882,956	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,855,177	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,101	0	2,687,310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,066,430	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85,367	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,107	0	2,057,026	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,272,079	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,434,653	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,392,149	9,687,039	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	34,248	46,852	0	4,370,346	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,596	6,436	0	435,419	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,971	1,663	0	420,226	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	23,409	9,645	40,258	2,556,422	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	237	7,379	240,976	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	11,398	92,339	3,070,965	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	11,705	113,329	3,497,794	0	88.03
91.00	09100	EMERGENCY	38,607	81,085	0	12,950,525	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	374,849	459,819	1,645,454	129,983,475	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,776	27,222	0	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	100	0	0	0	194.01
194.02	07952	FOUNDATION	0	693	0	0	0	194.02
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)	180,696	854,806	998,736	1,248,080	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.482050	1.836760	0.597089	0.009602	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,054	141,000	64,909	32,686	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037492	0.302973	0.038805	0.000251	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-0210

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

Worksheet B-2

Date/Time Prepared:
1/26/2021 7:53 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY		1	64.00	520,268 7.00
8.00		IV THERAPY		1	30.00	-520,268 8.00

Worksheet C
Part I
Date/Time Prepared:

MCRIF32 - 16.6.170.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/26/2021 7:53 am

			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	3,474,531		3,474,531		30.00
40.00	04000	SUBPROVIDER - IPF	11,082,537		11,082,537		40.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,136,229	4,434,190	5,570,419	0.423298	50.00
53.00	05300	ANESTHESIOLOGY	597,269	2,713,290	3,310,559	0.029911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,601	4,556,392	4,869,993	0.308938	54.00
54.01	05401	ULTRASOUND	611,406	3,677,318	4,288,724	0.115674	54.01
54.02	03440	MAMMOGRAPHY	881	513,079	513,960	0.488081	54.02
56.00	05600	RADIOISOTOPE	184,821	2,937,102	3,121,923	0.205929	56.00
57.00	05700	CT SCAN	1,593,791	16,296,602	17,890,393	0.046598	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,826	3,100,247	3,213,073	0.125841	58.00
60.00	06000	LABORATORY	2,582,750	15,300,206	17,882,956	0.197909	60.00
64.00	06400	INTRAVENOUS THERAPY	326,624	843,349	1,169,973	0.444684	64.00
65.00	06500	RESPIRATORY THERAPY	2,122,573	1,732,604	3,855,177	0.312716	65.00
66.00	06600	PHYSICAL THERAPY	678,545	2,008,765	2,687,310	0.455393	66.00
67.00	06700	OCCUPATIONAL THERAPY	455,669	610,761	1,066,430	0.276793	67.00
68.00	06800	SPEECH PATHOLOGY	9,091	76,276	85,367	0.524289	68.00
69.00	06900	ELECTROCARDIOLOGY	270,132	1,786,894	2,057,026	0.136221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	820,558	1,451,521	2,272,079	0.142080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	681,569	753,084	1,434,653	1.093938	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,551,263	7,135,776	9,687,039	0.271898	73.00
75.00	07500	ASC (NON-DISTINCT PART)	121,144	4,249,202	4,370,346	0.366928	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,485	432,934	435,419	0.622318	76.00
76.97	07697	CARDIAC REHABILITATION	795	419,431	420,226	0.377682	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,556,422	2,556,422		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	240,976	240,976		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,070,965	3,070,965		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,497,794	3,497,794		88.03
91.00	09100	EMERGENCY	1,210,447	11,740,078	12,950,525	0.235254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	667,974	2,238,706	2,906,680	0.571776	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	31,609,511	98,373,964	129,983,475		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	31,609,511	98,373,964	129,983,475		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
40.00	04000 SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.423298			50.00
53.00	05300 ANESTHESIOLOGY	0.029911			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.308938			54.00
54.01	05401 ULTRASOUND	0.115674			54.01
54.02	03440 MAMMOGRAPHY	0.488081			54.02
56.00	05600 RADIOISOTOPE	0.205929			56.00
57.00	05700 CT SCAN	0.046598			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.125841			58.00
60.00	06000 LABORATORY	0.198216			60.00
64.00	06400 INTRAVENOUS THERAPY	0.444684			64.00
65.00	06500 RESPIRATORY THERAPY	0.312716			65.00
66.00	06600 PHYSICAL THERAPY	0.455393			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276793			67.00
68.00	06800 SPEECH PATHOLOGY	0.524289			68.00
69.00	06900 ELECTROCARDIOLOGY	0.136221			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142080			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.093938			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.271898			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.366928			75.00
76.00	03950 FAITH CENTER CHEMOTHERAPY	0.622318			76.00
76.97	07697 CARDIAC REHABILITATION	0.377682			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
88.03	08803 RURAL HEALTH CLINIC IV				88.03
91.00	09100 EMERGENCY	0.235789			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.571776			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
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: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/26/2021 7:53 am

			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	439,192	256	438,936	3,907	112.35	30.00
40.00	SUBPROVIDER - IPF	434,803	0	434,803	8,180	53.15	40.00
200.00	Total (lines 30 through 199)	873,995		873,739	12,087		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	1,628	182,906				
40.00	SUBPROVIDER - IPF	2,635	140,050				
200.00	Total (lines 30 through 199)	4,263	322,956				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		Title XVIII		Hospital		PPS	
		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	591,301	5,570,419	0.106150	577,822	61,336 50.00
53.00	05300	ANESTHESIOLOGY	25,254	3,310,559	0.007628	309,763	2,363 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,051	4,869,993	0.040462	282,857	11,445 54.00
54.01	05401	ULTRASOUND	75,789	4,288,724	0.017672	511,620	9,041 54.01
54.02	03440	MAMMOGRAPHY	39,106	513,960	0.076088	0	0 54.02
56.00	05600	RADIOISOTOPE	65,314	3,121,923	0.020921	147,627	3,089 56.00
57.00	05700	CT SCAN	137,464	17,890,393	0.007684	1,491,942	11,464 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,919	3,213,073	0.067200	96,390	6,477 58.00
60.00	06000	LABORATORY	242,069	17,882,956	0.013536	2,131,099	28,847 60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,169,973	0.000000	187,882	0 64.00
65.00	06500	RESPIRATORY THERAPY	85,253	3,855,177	0.022114	1,391,547	30,773 65.00
66.00	06600	PHYSICAL THERAPY	96,401	2,687,310	0.035873	315,770	11,328 66.00
67.00	06700	OCCUPATIONAL THERAPY	8,175	1,066,430	0.007666	235,500	1,805 67.00
68.00	06800	SPEECH PATHOLOGY	605	85,367	0.007087	7,035	50 68.00
69.00	06900	ELECTROCARDIOLOGY	73,128	2,057,026	0.035550	241,569	8,588 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,202	2,272,079	0.001849	426,794	789 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,129	1,434,653	0.013334	506,740	6,757 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,082	9,687,039	0.007957	958,703	7,628 73.00
75.00	07500	ASC (NON-DISTINCT PART)	209,462	4,370,346	0.047928	61,307	2,938 75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	40,123	435,419	0.092148	2,164	199 76.00
76.97	07697	CARDIAC REHABILITATION	5,310	420,226	0.012636	795	10 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	308,879	2,556,422	0.120825	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	26,179	240,976	0.108637	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	208,017	3,070,965	0.067737	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	272,796	3,497,794	0.077991	0	0 88.03
91.00	09100	EMERGENCY	255,338	12,950,525	0.019716	876,517	17,281 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	129,198	2,906,680	0.044449	375,140	16,675 92.00
200.00		Total (lines 50 through 199)	3,408,544	115,426,407		11,136,583	238,883 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/26/2021 7:53 am		
					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	0	0	0	0	0	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0		3,907	0.00		1,628	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0		8,180	0.00		2,635	40.00	
200.00		Total (lines 30 through 199)		0		12,087			4,263	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/26/2021 7:53 am	
			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	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/26/2021 7:53 am	
			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	0	0	5,570,419	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,310,559	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,869,993	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,288,724	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	513,960	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	3,121,923	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,890,393	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,213,073	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	17,882,956	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,169,973	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,855,177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,687,310	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,066,430	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85,367	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,057,026	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,272,079	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,434,653	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,687,039	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,370,346	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	435,419	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	420,226	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,556,422	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	240,976	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	3,070,965	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	3,497,794	0.000000	88.03
91.00	09100	EMERGENCY	0	0	0	12,950,525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,906,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	115,426,407		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/26/2021 7:53 am

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	0.000000	577,822	0	1,627,820	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	309,763	0	946,950	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	282,857	0	1,368,911	0	54.00
54.01	05401	ULTRASOUND	0.000000	511,620	0	1,290,490	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	147,627	0	1,278,263	0	56.00
57.00	05700	CT SCAN	0.000000	1,491,942	0	5,759,953	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	96,390	0	1,006,417	0	58.00
60.00	06000	LABORATORY	0.000000	2,131,099	0	2,763,825	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	187,882	0	343,849	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,391,547	0	596,822	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	315,770	0	20,348	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	235,500	0	10,888	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,035	0	875	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	241,569	0	672,587	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	426,794	0	434,640	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	506,740	0	339,163	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	958,703	0	3,351,078	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	61,307	0	1,363,727	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	2,164	0	265,615	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	795	0	218,485	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
91.00	09100	EMERGENCY	0.000000	876,517	0	3,033,849	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	375,140	0	682,505	0	92.00
200.00		Total (lines 50 through 199)		11,136,583	0	27,377,060	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 1/26/2021 7:53 am	
			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	0.423298	1,627,820	0	0	689,053	50.00
53.00	05300	ANESTHESIOLOGY	0.029911	946,950	0	0	28,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.308938	1,368,911	0	0	422,909	54.00
54.01	05401	ULTRASOUND	0.115674	1,290,490	0	0	149,276	54.01
54.02	03440	MAMMOGRAPHY	0.488081	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.205929	1,278,263	0	0	263,231	56.00
57.00	05700	CT SCAN	0.046598	5,759,953	0	0	268,402	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.125841	1,006,417	0	0	126,649	58.00
60.00	06000	LABORATORY	0.197909	2,763,825	0	0	546,986	60.00
64.00	06400	INTRAVENOUS THERAPY	0.444684	343,849	0	0	152,904	64.00
65.00	06500	RESPIRATORY THERAPY	0.312716	596,822	0	0	186,636	65.00
66.00	06600	PHYSICAL THERAPY	0.455393	20,348	0	0	9,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276793	10,888	0	0	3,014	67.00
68.00	06800	SPEECH PATHOLOGY	0.524289	875	0	0	459	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136221	672,587	0	0	91,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142080	434,640	0	0	61,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.093938	339,163	0	0	371,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.271898	3,351,078	0	509	911,151	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.366928	1,363,727	0	0	500,390	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.622318	265,615	0	0	165,297	76.00
76.97	07697	CARDIAC REHABILITATION	0.377682	218,485	0	0	82,518	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
91.00	09100	EMERGENCY	0.235254	3,033,849	0	105	713,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.571776	682,505	0	0	390,240	92.00
200.00		Subtotal (see instructions)		27,377,060	0	614	6,134,827	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		27,377,060	0	614	6,134,827	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 1/26/2021 7:53 am
			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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	138		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
91.00	09100	EMERGENCY	0	25		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	163		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	163		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part II Date/Time Prepared: 1/26/2021 7:53 am	
				Title XVIII		Subprovider - IPF		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	591,301	5,570,419	0.106150	25,350	2,691	50.00	
53.00	05300	ANESTHESIOLOGY	25,254	3,310,559	0.007628	7,157	55	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,051	4,869,993	0.040462	25,432	1,029	54.00	
54.01	05401	ULTRASOUND	75,789	4,288,724	0.017672	16,572	293	54.01	
54.02	03440	MAMMOGRAPHY	39,106	513,960	0.076088	0	0	54.02	
56.00	05600	RADIOISOTOPE	65,314	3,121,923	0.020921	6,452	135	56.00	
57.00	05700	CT SCAN	137,464	17,890,393	0.007684	98,800	759	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,919	3,213,073	0.067200	0	0	58.00	
60.00	06000	LABORATORY	242,069	17,882,956	0.013536	321,632	4,354	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	1,169,973	0.000000	22,993	0	64.00	
65.00	06500	RESPIRATORY THERAPY	85,253	3,855,177	0.022114	180,062	3,982	65.00	
66.00	06600	PHYSICAL THERAPY	96,401	2,687,310	0.035873	74,612	2,677	66.00	
67.00	06700	OCCUPATIONAL THERAPY	8,175	1,066,430	0.007666	11,283	86	67.00	
68.00	06800	SPEECH PATHOLOGY	605	85,367	0.007087	350	2	68.00	
69.00	06900	ELECTROCARDIOLOGY	73,128	2,057,026	0.035550	26,663	948	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,202	2,272,079	0.001849	17,444	32	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,129	1,434,653	0.013334	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	77,082	9,687,039	0.007957	459,193	3,654	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	209,462	4,370,346	0.047928	0	0	75.00	
76.00	03950	FAITH CENTER CHEMOTHERAPY	40,123	435,419	0.092148	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	5,310	420,226	0.012636	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	308,879	2,556,422	0.120825	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	26,179	240,976	0.108637	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	208,017	3,070,965	0.067737	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	272,796	3,497,794	0.077991	0	0	88.03	
91.00	09100	EMERGENCY	255,338	12,950,525	0.019716	140,067	2,762	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,906,680	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	3,279,346	115,426,407		1,434,062	23,459	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/26/2021 7:53 am	
				Title XVIII		Subprovider - IPF		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	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		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
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	0	0	88.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/26/2021 7:53 am	
			Title XVIII		Subprovider - IPF		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	0	0	5,570,419	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,310,559	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,869,993	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,288,724	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	513,960	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	3,121,923	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,890,393	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,213,073	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	17,882,956	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,169,973	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,855,177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,687,310	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,066,430	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	85,367	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,057,026	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,272,079	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,434,653	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,687,039	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,370,346	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	435,419	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	420,226	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,556,422	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	240,976	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	3,070,965	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	3,497,794	0.000000	88.03
91.00	09100	EMERGENCY	0	0	0	12,950,525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,906,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	115,426,407		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/26/2021 7:53 am	
				Title XVIII		Subprovider - IPF		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		0.000000	25,350	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	7,157	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	25,432	0	0	0	54.00
54.01	05401	ULTRASOUND		0.000000	16,572	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE		0.000000	6,452	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	98,800	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	321,632	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	22,993	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	180,062	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	74,612	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	11,283	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	350	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	26,663	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	17,444	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	459,193	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0.000000	0	0	0	0	88.03
91.00	09100	EMERGENCY		0.000000	140,067	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,434,062	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/26/2021 7:53 am
		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)		4,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,907	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)		2,757	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		115	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)		223	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		6	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)		15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,628	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)		63	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)		223	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		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,649,650	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)		943	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)		2,358	25.00
26.00	Total swing-bed cost (see instructions)		3,301	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,646,349	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)		5,646,349	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)		1,445.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,352,769	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,352,769	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
1/26/2021 7:53 am

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,020,140	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,372,909	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)					182,906	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					238,883	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					421,789	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,951,120	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,150	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,445.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,661,969	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		Title XVIII		Hospital	PPS	
		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	439,192	5,649,650	0.077738	1,661,969	129,198
91.00	Nursing School cost	0	5,649,650	0.000000	1,661,969	0
92.00	Allied health cost	0	5,649,650	0.000000	1,661,969	0
93.00	All other Medical Education	0	5,649,650	0.000000	1,661,969	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/26/2021 7:53 am
		Title XVIII	Subprovider - IPF	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)		8,180	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,180	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)		8,180	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)		2,635	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)		6,481,426	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)		6,481,426	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)		6,481,426	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)		792.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,087,842	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,087,842	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/26/2021 7:53 am		
				Title XVIII	Subprovider - IPF	PPS		
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
		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)						358,213	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,446,055	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)						140,050	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						23,459	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						163,509	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,282,546	53.00
		TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
		PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
		PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
		PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)						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: 14-0210 Component CCN: 14-S210		Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII		Subprovider - IPF	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	434,803	6,481,426	0.067084	0	0 90.00
91.00	Nursing School cost	0	6,481,426	0.000000	0	0 91.00
92.00	Allied health cost	0	6,481,426	0.000000	0	0 92.00
93.00	All other Medical Education	0	6,481,426	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/26/2021 7:53 am	
			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		2,027,191		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.423298	577,822	244,591	50.00
53.00	05300	ANESTHESIOLOGY	0.029911	309,763	9,265	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.308938	282,857	87,385	54.00
54.01	05401	ULTRASOUND	0.115674	511,620	59,181	54.01
54.02	03440	MAMMOGRAPHY	0.488081	0	0	54.02
56.00	05600	RADIOISOTOPE	0.205929	147,627	30,401	56.00
57.00	05700	CT SCAN	0.046598	1,491,942	69,522	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.125841	96,390	12,130	58.00
60.00	06000	LABORATORY	0.198216	2,131,099	422,418	60.00
64.00	06400	INTRAVENOUS THERAPY	0.444684	187,882	83,548	64.00
65.00	06500	RESPIRATORY THERAPY	0.312716	1,391,547	435,159	65.00
66.00	06600	PHYSICAL THERAPY	0.455393	315,770	143,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276793	235,500	65,185	67.00
68.00	06800	SPEECH PATHOLOGY	0.524289	7,035	3,688	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136221	241,569	32,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142080	426,794	60,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.093938	506,740	554,342	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.271898	958,703	260,669	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.366928	61,307	22,495	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.622318	2,164	1,347	76.00
76.97	07697	CARDIAC REHABILITATION	0.377682	795	300	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.235789	876,517	206,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.571776	375,140	214,496	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,136,583	3,020,140	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)		11,136,583		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	Subprovider - IPF	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
40.00	04000 SUBPROVIDER - IPF		3,565,043		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.423298	25,350	10,731	50.00
53.00	05300 ANESTHESIOLOGY	0.029911	7,157	214	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.308938	25,432	7,857	54.00
54.01	05401 ULTRASOUND	0.115674	16,572	1,917	54.01
54.02	03440 MAMMOGRAPHY	0.488081	0	0	54.02
56.00	05600 RADIOISOTOPE	0.205929	6,452	1,329	56.00
57.00	05700 CT SCAN	0.046598	98,800	4,604	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.125841	0	0	58.00
60.00	06000 LABORATORY	0.198216	321,632	63,753	60.00
64.00	06400 INTRAVENOUS THERAPY	0.444684	22,993	10,225	64.00
65.00	06500 RESPIRATORY THERAPY	0.312716	180,062	56,308	65.00
66.00	06600 PHYSICAL THERAPY	0.455393	74,612	33,978	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276793	11,283	3,123	67.00
68.00	06800 SPEECH PATHOLOGY	0.524289	350	184	68.00
69.00	06900 ELECTROCARDIOLOGY	0.136221	26,663	3,632	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142080	17,444	2,478	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.093938	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.271898	459,193	124,854	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.366928	0	0	75.00
76.00	03950 FAITH CENTER CHEMOTHERAPY	0.622318	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.377682	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100 EMERGENCY	0.235789	140,067	33,026	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.571776	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,434,062	358,213	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)		1,434,062		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0210 Component CCN: 14-U210	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/26/2021 7:53 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	PPS	
			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
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.423298	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.029911	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.308938	5,110	1,579	54.00
54.01	05401	ULTRASOUND	0.115674	3,334	386	54.01
54.02	03440	MAMMOGRAPHY	0.488081	0	0	54.02
56.00	05600	RADIOISOTOPE	0.205929	0	0	56.00
57.00	05700	CT SCAN	0.046598	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.125841	0	0	58.00
60.00	06000	LABORATORY	0.198216	65,531	12,989	60.00
64.00	06400	INTRAVENOUS THERAPY	0.444684	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.312716	84,091	26,297	65.00
66.00	06600	PHYSICAL THERAPY	0.455393	105,230	47,921	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276793	86,039	23,815	67.00
68.00	06800	SPEECH PATHOLOGY	0.524289	855	448	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136221	1,520	207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.142080	27,922	3,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.093938	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.271898	113,846	30,954	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.366928	656	241	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.622318	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.377682	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.235789	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.571776	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		494,134	148,804	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)		494,134		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
1/26/2021 7:53 am

		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)			867,652	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,728,724	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)			4,094	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)			33.88	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)			4.55	30.00
31.00	Percentage of Medicaid patient days (see instructions)			16.07	31.00
32.00	Sum of lines 30 and 31			20.62	32.00
33.00	Allowable disproportionate share percentage (see instructions)			6.23	33.00
34.00	Disproportionate share adjustment (see instructions)			56,014	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/26/2021 7:53 am	
		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	35.00
35.01	Factor 3 (see instructions)		0.000079490	0.000142815	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		639,835	1,192,594	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		161,274	892,816	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,054,090		36.00
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		40.00
			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	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,710,574		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		4,318,371		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			4,710,574	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			290,352	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			0	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).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			5,000,926	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,000,926	61.00
62.00	Deductibles billed to program beneficiaries			611,688	62.00
63.00	Coinsurance billed to program beneficiaries			4,774	63.00
64.00	Allowable bad debts (see instructions)			288,057	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			187,237	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			215,967	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,571,701	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)			-31,704	70.93
70.94	HRR adjustment amount (see instructions)			-16,394	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/26/2021 7:53 am
		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	175,476	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	588,402	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)		5,287,481	71.00
71.01	Sequestration adjustment (see instructions)		88,301	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		4,999,904	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		199,276	74.00
74.01	Balance due provider/program-PARHM (see instructions)			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)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	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	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	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/26/2021 7:53 am

		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	867,652	0	867,652		867,652
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,728,724	0		2,728,724	2,728,724
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	4,094	0		4,094	4,094
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	0.0623	0.0623	0.0623	0.0623	
11.00	Disproportionate share adjustment (see instructions)	34.00	56,014	0	13,514	42,500	56,014
11.01	Uncompensated care payments	36.00	1,054,090	0	161,274	892,816	1,054,090
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	4,710,574	0	1,042,440	3,668,134	4,710,574
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,710,574	0	1,042,440	3,668,134	4,710,574
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	290,352	0	71,157	219,195	290,352

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/26/2021 7:53 am

		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
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	1,113,597	3,887,329	5,000,926
		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	289,877	0	71,157	218,720	289,877
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	475	0	0	475	475
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	290,352	0	71,157	219,195	290,352
		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				0.157576	0.151364	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			175,476		175,476
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				588,402	588,402
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/26/2021 7:53 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		163	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,134,827	2.00
3.00	OPPS payments		4,904,807	3.00
4.00	Outlier payment (see instructions)		6,368	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		163	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		614	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)		614	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)		614	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		451	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)		163	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)		4,911,175	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		990,268	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)		3,921,070	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)		3,921,070	30.00
31.00	Primary payer payments		1,046	31.00
32.00	Subtotal (line 30 minus line 31)		3,920,024	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)		268,137	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		174,289	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		196,775	36.00
37.00	Subtotal (see instructions)		4,094,313	37.00
38.00	MSP-LCC reconciliation amount from PS&R		183	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,094,130	40.00
40.01	Sequestration adjustment (see instructions)		68,372	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		4,070,852	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)		-45,094	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/26/2021 7:53 am

		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		4,999,904		4,070,852	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)		4,999,904		4,070,852	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		199,276		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		45,094	6.02	
7.00	Total Medicare program liability (see instructions)		5,199,180		4,025,758	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0210
 Component CCN: 14-S210

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/26/2021 7:53 am

		Title XVIII		Subprovider - IPF		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		2,130,581		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,130,581		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		44,345		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,174,926		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0210
 Component CCN: 14-U210

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/26/2021 7:53 am

		Title XVIII		Swing Beds - SNF		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		138,650		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		138,650		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		42		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		138,692		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
1/26/2021 7:53 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0210 Component CCN: 14-U210	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2 Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		146,927	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		286	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		146,927	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		146,927	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		146,927	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,880	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		141,047	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		141,047	0	19.00
19.01	Sequestration adjustment (see instructions)		2,355	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		138,650	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		42	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 1/26/2021 7:53 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,398,565	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		22.349727	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,398,565	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,398,565	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,398,565	18.00
19.00	Deductibles		231,616	19.00
20.00	Subtotal (line 18 minus line 19)		2,166,949	20.00
21.00	Coinurance		73,084	21.00
22.00	Subtotal (line 20 minus line 21)		2,093,865	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		181,537	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		117,999	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,385	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,211,864	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,211,864	31.00
31.01	Sequestration adjustment (see instructions)		36,938	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		2,130,581	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		44,345	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0210

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

Worksheet G

Date/Time Prepared:
1/26/2021 7:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	18,980,557	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,137,649	0	0	0	4.00
5.00	Other receivable	1,301,083	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,842,109	0	0	0	7.00
8.00	Prepaid expenses	626,416	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)	29,887,814	0	0	0	11.00
FIXED ASSETS						
12.00	Land	772,443	0	0	0	12.00
13.00	Land improvements	688,854	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,304,995	0	0	0	15.00
16.00	Accumulated depreciation	-30,843,267	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	18,686,455	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,686,801	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,296,281	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,676,519	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	134,908	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,811,427	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,995,522	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,657,387	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,796,844	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,471,395	0	0	0	40.00
41.00	Deferred income	10,650,002	0	0	0	41.00
42.00	Accelerated payments	4,176,711	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,496,078	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,248,417	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	20,045,267	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,045,267	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	43,293,684	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,701,838				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	18,701,838	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,995,522	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0210

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

Worksheet G-1

Date/Time Prepared:
1/26/2021 7:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,683,648		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,018,190				2.00
3.00	Total (sum of line 1 and line 2)		18,701,838		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,701,838		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,701,838		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0210

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/26/2021 7:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,270,978		3,270,978	1.00
2.00	SUBPROVIDER - IPF	11,082,537		11,082,537	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	191,646		191,646	5.00
6.00	Swing bed - NF	11,907		11,907	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,557,068		14,557,068	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,557,068		14,557,068	17.00
18.00	Ancillary services	15,174,019	75,029,026	90,203,045	18.00
19.00	Outpatient services	1,878,421	13,978,784	15,857,205	19.00
20.00	RURAL HEALTH CLINIC	0	2,556,422	2,556,422	20.00
20.01	RURAL HEALTH CLINIC II	0	240,976	240,976	20.01
20.02	RURAL HEALTH CLINIC III	0	3,070,965	3,070,965	20.02
20.03	RURAL HEALTH CLINIC IV	0	3,497,794	3,497,794	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	PROFESSIONAL FEES	3,175,642	8,184,614	11,360,256	27.00
27.01	PHYSICIAN CLINICS	0	3,595,754	3,595,754	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	34,785,150	110,154,335	144,939,485	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,696,115		29.00
30.00	FOUNDATION EXPENSES	71,312			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)		71,312		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)		56,767,427		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0210

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

Worksheet G-3

Date/Time Prepared:
1/26/2021 7:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,939,485	1.00
2.00	Less contractual allowances and discounts on patients' accounts	94,669,138	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,270,347	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,767,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,497,080	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	336,048	6.00
7.00	Income from investments	132,164	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	186	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	97,720	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	28,760	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	5,354	21.00
22.00	Rental of hospital space	104,062	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PHARMACY	1,794,071	24.00
24.01	PPP LOAN FORGIVENESS INCOME	3,494,456	24.01
24.02	MISCELLANEOUS INCOME	178,093	24.02
24.03	REFERENCE LAB CONTRACTUAL	1,488,170	24.03
24.04	FOUNDATION REVENUE	92,456	24.04
24.50	COVID-19 PHE Funding	45,641	24.50
25.00	Total other income (sum of lines 6-24)	7,797,181	25.00
26.00	Total (line 5 plus line 25)	1,300,101	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	127,968	27.00
27.01	UNREALIZED LOSS ON INVESTMENTS	153,943	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	281,911	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,018,190	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 1/26/2021 7:53 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		289,877	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		475	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)		7.53	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)		290,352	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: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

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

Date/Time Prepared:

1/26/2021 7:53 am

		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	464,739	0	464,739	-45,317	419,422 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	381,248	0	381,248	-30,511	350,737 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	172,858	0	172,858	0	172,858 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	31,155	0	31,155	0	31,155 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	577	0	577	-577	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,050,577	0	1,050,577	-76,405	974,172 10.00
11.00	Physician Services Under Agreement	0	285,062	285,062	-14,113	270,949 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	285,062	285,062	-14,113	270,949 14.00
15.00	Medical Supplies	0	1,086	1,086	31,869	32,955 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,086	1,086	31,869	32,955 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,050,577	286,148	1,336,725	-58,649	1,278,076 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	40,258	40,258	-31,869	8,389 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	89,941	89,941 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	40,258	40,258	58,072	98,330 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	57,720	57,720	-20,281	37,439 29.00
30.00	Administrative Costs	171,641	107,780	279,421	-18,477	260,944 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	171,641	165,500	337,141	-38,758	298,383 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,222,218	491,906	1,714,124	-39,335	1,674,789 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	419,422	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	350,737	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	172,858	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	31,155	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	974,172	10.00
11.00	Physician Services Under Agreement	0	270,949	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	270,949	14.00
15.00	Medical Supplies	0	32,955	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	32,955	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,278,076	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	8,389	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	89,941	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	98,330	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	37,439	29.00
30.00	Administrative Costs	0	260,944	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	298,383	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,674,789	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8560

From 07/01/2019
To 06/30/2020Date/Time Prepared:
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		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,280	0	3,280	0	3,280
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	59,810	0	59,810	0	59,810
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	15,880	0	15,880	0	15,880
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)	78,970	0	78,970	0	78,970
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	-174	-174	6,029	5,855
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	-174	-174	6,029	5,855
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	78,970	-174	78,796	6,029	84,825
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	7,379	7,379	-6,029	1,350
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	7,379	7,379	-6,029	1,350
FACILITY OVERHEAD						
29.00	Facility Costs	0	10,985	10,985	-10,644	341
30.00	Administrative Costs	15,786	25,239	41,025	-3,373	37,652
31.00	Total Facility Overhead (sum of lines 29 and 30)	15,786	36,224	52,010	-14,017	37,993
32.00	Total facility costs (sum of lines 22, 28 and 31)	94,756	43,429	138,185	-14,017	124,168

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8560

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

		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	3,280	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	59,810	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	15,880	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	78,970	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	5,855	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	5,855	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	84,825	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,350	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	1,350	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	341	29.00
30.00	Administrative Costs	0	37,652	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	37,993	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	124,168	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

1/26/2021 7:53 am

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	439,756	0	439,756	-3,084	436,672
2.00 Physician Assistant	1,199	0	1,199	0	1,199
3.00 Nurse Practitioner	269,872	0	269,872	-5,997	263,875
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	162,263	0	162,263	0	162,263
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	43,293	0	43,293	0	43,293
9.00 Other Facility Health Care Staff Costs	1,256	0	1,256	0	1,256
10.00 Subtotal (sum of lines 1 through 9)	917,639	0	917,639	-9,081	908,558
11.00 Physician Services Under Agreement	0	230,318	230,318	-3,483	226,835
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	230,318	230,318	-3,483	226,835
15.00 Medical Supplies	0	862	862	53,687	54,549
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	862	862	53,687	54,549
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	917,639	231,180	1,148,819	41,123	1,189,942
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	92,339	92,339	-53,687	38,652
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	12,564	12,564
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	92,339	92,339	-41,123	51,216
FACILITY OVERHEAD					
29.00 Facility Costs	0	29,396	29,396	-12,142	17,254
30.00 Administrative Costs	183,838	211,824	395,662	-5,764	389,898
31.00 Total Facility Overhead (sum of lines 29 and 30)	183,838	241,220	425,058	-17,906	407,152
32.00 Total facility costs (sum of lines 22, 28 and 31)	1,101,477	564,739	1,666,216	-17,906	1,648,310

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	436,672	1.00
2.00	Physician Assistant	0	1,199	2.00
3.00	Nurse Practitioner	0	263,875	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	162,263	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	43,293	8.00
9.00	Other Facility Health Care Staff Costs	0	1,256	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	908,558	10.00
11.00	Physician Services Under Agreement	0	226,835	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	226,835	14.00
15.00	Medical Supplies	0	54,549	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	54,549	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,189,942	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	38,652	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	12,564	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	51,216	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	17,254	29.00
30.00	Administrative Costs	0	389,898	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	407,152	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,648,310	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	365,717	0	365,717	-2,336	363,381	1.00
2.00	Physician Assistant	174,923	0	174,923	-8,063	166,860	2.00
3.00	Nurse Practitioner	30,074	0	30,074	-132	29,942	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	132,913	0	132,913	0	132,913	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	40,436	0	40,436	0	40,436	8.00
9.00	Other Facility Health Care Staff Costs	235	0	235	0	235	9.00
10.00	Subtotal (sum of lines 1 through 9)	744,298	0	744,298	-10,531	733,767	10.00
11.00	Physician Services Under Agreement	0	651,524	651,524	-35,629	615,895	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	651,524	651,524	-35,629	615,895	14.00
15.00	Medical Supplies	0	1,181	1,181	50,638	51,819	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,181	1,181	50,638	51,819	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	744,298	652,705	1,397,003	4,478	1,401,481	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	113,329	113,329	-50,638	62,691	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	46,160	46,160	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	113,329	113,329	-4,478	108,851	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	197,864	197,864	-184,170	13,694	29.00
30.00	Administrative Costs	309,452	199,189	508,641	-8,418	500,223	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	309,452	397,053	706,505	-192,588	513,917	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,053,750	1,163,087	2,216,837	-192,588	2,024,249	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/26/2021 7:53 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	363,381	1.00
2.00	Physician Assistant	0	166,860	2.00
3.00	Nurse Practitioner	0	29,942	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	132,913	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	40,436	8.00
9.00	Other Facility Health Care Staff Costs	0	235	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	733,767	10.00
11.00	Physician Services Under Agreement	0	615,895	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	615,895	14.00
15.00	Medical Supplies	0	51,819	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	51,819	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,401,481	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	62,691	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	46,160	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	108,851	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	13,694	29.00
30.00	Administrative Costs	0	500,223	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	513,917	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,024,249	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-3473

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

Date/Time Prepared:

1/26/2021 7:53 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.62	5,504	4,200	6,804		1.00
2.00	Physician Assistant	0.16	1,361	2,100	336		2.00
3.00	Nurse Practitioner	2.41	7,380	2,100	5,061		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.19	14,245		12,201	14,245	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	0.54	715			715	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)	4.73	14,960			14,960	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)					1,278,076	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					98,330	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,376,406	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.928560	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					298,383	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,577,748	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,876,131	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,876,131	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,742,100	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,020,176	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8560

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

1/26/2021 7:53 am

		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	0.00	2	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.50	1,261	2,100	1,050
4.00	Subtotal (sum of lines 1 through 3)	0.50	1,263	1,050	1,263
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.50	1,263		1,263
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				84,825
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				1,350
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				86,175
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.984334
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				37,993
15.00	Parent provider overhead allocated to facility (see instructions)				118,746
16.00	Total overhead (sum of lines 14 and 15)				156,739
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				156,739
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				154,284
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				239,109

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8589

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

Date/Time Prepared:

1/26/2021 7:53 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.03	5,099	4,200	4,326		1.00
2.00	Physician Assistant	0.39	3,235	2,100	819		2.00
3.00	Nurse Practitioner	1.11	5,326	2,100	2,331		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.53	13,660		7,476	13,660	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.53	13,660			13,660	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)					1,189,942	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					51,216	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,241,158	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.958735	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					407,152	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,329,042	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,736,194	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,736,194	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,664,550	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,854,492	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8590

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

1/26/2021 7:53 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.12	6,620	4,200	4,704		1.00
2.00	Physician Assistant	0.85	4,238	2,100	1,785		2.00
3.00	Nurse Practitioner	0.62	4,350	2,100	1,302		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.59	15,208		7,791	15,208	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.59	15,208			15,208	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)					1,401,481	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					108,851	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,510,332	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.927929	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					513,917	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,498,028	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,011,945	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,011,945	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,866,942	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,268,423	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 1/26/2021 7:53 am		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,020,176	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			80,198	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,939,978	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,960	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)			14,960	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			196.52	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			196.52	196.52	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	4,547	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	893,576	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	198	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	38,911	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	38,911	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	932,487	16.00
16.01	Total program charges (see instructions)(from contractor's records)				763,413	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				13,747	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				16,791	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.)				675,539	16.04
16.05	Total program cost (see instructions)			0	692,330	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				71,272	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				135,761	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				692,330	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				50,422	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				742,752	22.00
23.00	Allowable bad debts (see instructions)				73,507	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				47,780	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)				790,532	26.00
26.01	Sequestration adjustment (see instructions)				13,202	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				604,160	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)				173,170	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 1/26/2021 7:53 am	
		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)			239,109	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			17,860	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			221,249	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,263	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)			1,263	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			175.18	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		175.18	175.18	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		258	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		45,196	0	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	45,196	16.00
16.01	Total program charges (see instructions)(from contractor's records)			42,989	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,368	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,438	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.)			34,706	16.04
16.05	Total program cost (see instructions)		0	36,144	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			376	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			8,249	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			36,144	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,449	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			46,593	22.00
23.00	Allowable bad debts (see instructions)			491	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			319	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)			46,912	26.00
26.01	Sequestration adjustment (see instructions)			783	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			33,078	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)			13,051	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8589		Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	RHC III	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,854,492	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			138,877	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,715,615	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,660	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)			13,660	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.80	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		198.80	198.80	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,595	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	714,686	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	14	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	2,783	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	2,783	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	717,469	16.00
16.01	Total program charges (see instructions)(from contractor's records)			712,944	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			106,116	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			106,790	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.)			437,462	16.04
16.05	Total program cost (see instructions)		0	544,252	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			63,851	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			108,596	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			544,252	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			67,580	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			611,832	22.00
23.00	Allowable bad debts (see instructions)			3,412	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,218	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)			614,050	26.00
26.01	Sequestration adjustment (see instructions)			10,255	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			605,442	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)			-1,647	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8590		Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	RHC IV	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)			3,268,423	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			126,358	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,142,065	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,208	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)			15,208	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			206.61	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		206.61	206.61	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,739	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	772,515	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	150	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	30,992	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	30,992	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	803,507	16.00
16.01	Total program charges (see instructions)(from contractor's records)			741,968	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			103,833	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			112,445	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.)			500,347	16.04
16.05	Total program cost (see instructions)		0	612,792	16.05
17.00	Primary payer amounts			140	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			65,628	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			114,501	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			612,652	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			64,881	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			677,533	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)			677,533	26.00
26.01	Sequestration adjustment (see instructions)			11,315	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			599,712	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)			66,506	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		974,172	974,172	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000415	0.001709	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		404	1,665	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		16,212	15,657	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		16,616	17,322	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,278,076	1,278,076	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,742,100	1,742,100	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013001	0.013553	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		22,649	23,611	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		39,265	40,933	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		105	432	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		373.95	94.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		72	248	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		26,924	23,498	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)			80,198	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			50,422	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0210 Component CCN: 14-8560	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/26/2021 7:53 am	
		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)		78,970	78,970	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000805	0.003081	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		64	243	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,591	2,438	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,655	2,681	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		84,825	84,825	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		154,284	154,284	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.043089	0.031606	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		6,648	4,876	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		10,303	7,557	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		23	88	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		447.96	85.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		17	33	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,615	2,834	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)			17,860	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)			10,449	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0210
Component CCN: 14-8589Period:
From 07/01/2019
To 06/30/2020Worksheet M-4
Date/Time Prepared:
1/26/2021 7:53 am

		Title XVIII		RHC III		Cost	
				Pneumococcal	Influenza		
				1.00	2.00		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			908,558	908,558	1.00	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			0.001037	0.003592	2.00	
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			942	3,264	3.00	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			31,246	22,441	4.00	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			32,188	25,705	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)			1,189,942	1,189,942	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)			1,664,550	1,664,550	7.00	
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			0.027050	0.021602	8.00	
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			45,026	35,958	9.00	
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			77,214	61,663	10.00	
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)			196	679	11.00	
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			393.95	90.81	12.00	
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			107	280	13.00	
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			42,153	25,427	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)				138,877	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)				67,580	16.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0210 Component CCN: 14-8590	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/26/2021 7:53 am	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		733,767	733,767	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001219	0.003612	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		894	2,650	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		28,462	22,176	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		29,356	24,826	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,401,481	1,401,481	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,866,942	1,866,942	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.020946	0.017714	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		39,105	33,071	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		68,461	57,897	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		193	572	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		354.72	101.22	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		111	252	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		39,374	25,507	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)			126,358	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)			64,881	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/26/2021 7:53 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		604,160	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		604,160	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		173,170	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		777,330	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-8560	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/26/2021 7:53 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,078	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		33,078	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		13,051	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		46,129	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-8589	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/26/2021 7:53 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			605,442	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			605,442	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			1,647	6.02
7.00	Total Medicare program liability (see instructions)			603,795	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-8590	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/26/2021 7:53 am
		RHC IV	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		599,712	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		599,712	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		66,506	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		666,218	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00