

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: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/24/2020 8:56 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/24/2020	Time: 8:56 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KIRBY HOSPITAL (14-1301) 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) KIMBERLY AVIS

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	-161,576	80,066	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-154,302	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		2,284		0	10.00
10.01	RURAL HEALTH CLINIC II	0		56,715		0	10.01
10.02	RURAL HEALTH CLINIC III	0		30,076		0	10.02
200.00	Total	0	-315,878	169,141	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: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 8:56 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 MEDICAL CENTER DRIVE			PO Box:				1.00	
2.00	City: MONTICELLO			State: IL		Zip Code: 61856		County: PIATT	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		KIRBY HOSPITAL - SWING BED	142301	16580		08/08/1999	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O
15.01	Hospital-Based Health Clinic - RHC II		KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O
15.02	Hospital-Based Health Clinic - RHC III		CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	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		
22.03	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	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/24/2020 8:56 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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.					1		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.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
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: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 8:56 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/24/2020 8:56 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)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 8:56 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?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	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.	Y	N	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 8:56 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:	144,243	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: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 8:56 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.					Y		05/19/2020	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.							Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							Y	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	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	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		
								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: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 8:56 am	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N 1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N 1.00	Type 2.00	Date 3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N 1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/06/2020	Y	10/06/2020
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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/24/2020 8:56 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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		Y		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.		Y		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.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	CLIFTONLARSONALLEN, 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: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 8:56 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 8:56 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	16	5,856	6,264.00	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)		16	5,856	6,264.00	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)		16	5,856	6,264.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		16				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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 8:56 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)	153	8	261			1.00
2.00	HMO and other (see instructions)	56	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	629	0	1,072			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	432			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	782	8	1,765			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)	782	8	1,765	0.00	188.71	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	286	0	2,094	0.00	6.55	26.00
26.01	RURAL HEALTH CLINIC II	2,686	0	16,418	0.00	31.98	26.01
26.02	RURAL HEALTH CLINIC III	435	0	2,675	0.00	6.98	26.02
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	234.22	27.00
28.00	Observation Bed Days		0	230			28.00
29.00	Ambulance Trips	400					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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	47	3	82	1.00
2.00 HMO and other (see instructions)			16	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	47	3	82	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1301 Component CCN: 14-3438		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/24/2020 8:56 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				108 SOUTH MAIN STREET		1.00		
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				ATWOOD IL 61913		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		16:30		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				DOUGLAS				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		08:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3438

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

Date/Time Prepared:

11/24/2020 8:56 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	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1301 Component CCN: 14-3495		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/24/2020 8:56 am		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street			1000 MEDICAL CENTER DRIVE			1.00			
			City		State		ZIP Code			
			1.00		2.00		3.00			
2.00	City, State, ZIP Code, County			MONTICELLO IL 61856			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			07:00		18:00		07:00		11.00
				1.00		2.00				
12.00	Have you received an approval for an exception to the productivity standard?				Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number									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			PIATT						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			18:00		07:00		18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3495

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

Date/Time Prepared:

11/24/2020 8:56 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	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8	
Component CCN: 14-8566		Date/Time Prepared: 11/24/2020 8:56 am			
		RHC III		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		407 S. JACKSON STREET, SUITE A		1.00
	City		State		ZIP Code
	1.00		2.00		3.00
2.00	City, State, ZIP Code, County		CERRO GORDO IL 61818		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		5.00	
11.00	Facility hours of operations (1)				
	CLINIC		07:00 17:30		07:00 11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		0 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.				0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N		V	
		1.00		2.00	
		XVIII		XIX	
		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		PIATT		2.00
		Tuesday		Wednesday	
		to		from to	
		6.00		7.00 8.00	
		Thursday		from to	
		9.00		10.00	
Facility hours of operations (1)					
11.00	CLINIC		16:30 08:00		17:30 08:00 16:30 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-8566

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

Date/Time Prepared:

11/24/2020 8:56 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	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/24/2020 8:56 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)			0.434710 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,777,515 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	10,375,575		6.00
7.00	Medicaid cost (line 1 times line 6)	4,510,366		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)	732,851		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	732,851		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)	1,279,756	0	1,279,756 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	556,323	0	556,323 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	556,323	0	556,323 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)	2,668,017		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	223,706		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	344,163		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,323,854		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,130,660		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,686,983		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,419,834		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1301

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

Worksheet A

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		4,324,216	4,324,216	-60,859	4,263,357	1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING		0	0	18,696	18,696	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING		0	0	93,201	93,201	1.02
1.03	00103	CROSSFIT BUILDING		0	0	113,444	113,444	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE		0	0	14,606	14,606	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,723,780	1,723,780	21,999	1,745,779	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	82,617	128,015	210,632	16,967	227,599	4.00
5.01	00540	PFS & REGISTRATION	494,190	546,884	1,041,074	510,598	1,551,672	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	2,546,777	4,698,519	7,245,296	-81,034	7,164,262	5.02
6.00	00600	MAINTENANCE & REPAIRS	291,321	276,221	567,542	0	567,542	6.00
7.00	00700	OPERATION OF PLANT	0	343,430	343,430	-125,033	218,397	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	47,960	47,960	8.00
9.00	00900	HOUSEKEEPING	291,445	178,605	470,050	0	470,050	9.00
10.00	01000	DIETARY	458,500	308,344	766,844	-625,006	141,838	10.00
11.00	01100	CAFETERIA	0	0	0	614,935	614,935	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,743	63,936	192,679	-13,879	178,800	14.00
15.00	01500	PHARMACY	187,876	561,761	749,637	-447,891	301,746	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	593,028	340,333	933,361	0	933,361	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	364,112	49,768	413,880	0	413,880	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,296,576	1,180,958	2,477,534	-30,706	2,446,828	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	586,187	1,946,610	2,532,797	-624,448	1,908,349	50.00
53.00	05300	ANESTHESIOLOGY	0	529,226	529,226	0	529,226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	758,341	1,206,607	1,964,948	-187,342	1,777,606	54.00
54.01	03952	ULTRASOUND	0	22,824	22,824	178,495	201,319	54.01
60.00	06000	LABORATORY	605,972	1,013,556	1,619,528	0	1,619,528	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	620,437	240,326	860,763	-5,512	855,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,644	38,295	169,939	0	169,939	67.00
68.00	06800	SPEECH PATHOLOGY	13,483	16,344	29,827	0	29,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,796	21,796	16,559	38,355	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	360,253	360,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	322,704	322,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	447,891	447,891	73.00
76.00	03950	SLEEP LAB	118,899	59,933	178,832	-674	178,158	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	4,871	4,871	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	15,986	266,225	282,211	818	283,029	76.02
76.03	03030	WOUNDCARE	2,627	2,369	4,996	2,299	7,295	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	367,763	203,184	570,947	-81,106	489,841	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,850,139	1,137,890	3,988,029	-350,383	3,637,646	88.01
88.02	08802	RURAL HEALTH CLINIC III	459,574	193,799	653,373	-90,090	563,283	88.02
91.00	09100	EMERGENCY	1,113,916	2,955,639	4,069,555	-136,868	3,932,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	423,320	270,387	693,707	67,009	760,716	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,803,473	24,849,780	39,653,253	-7,526	39,645,727	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,285	50,285	14,430	64,715	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	140,267	87,034	227,301	0	227,301	194.00
194.01	07951	FOUNDATION	69,210	51,699	120,909	0	120,909	194.01
194.02	07952	CROSSFIT	96,140	69,671	165,811	-6,904	158,907	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	15,109,090	25,108,469	40,217,559	0	40,217,559	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1301

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

Worksheet A

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-66,287	4,197,070	1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	18,696	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	93,201	1.02
1.03	00103	CROSSFIT BUILDING	0	113,444	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	14,606	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,745,779	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6	227,593	4.00
5.01	00540	PFS & REGISTRATION	0	1,551,672	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	-1,316,857	5,847,405	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	567,542	6.00
7.00	00700	OPERATION OF PLANT	11,746	230,143	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,960	8.00
9.00	00900	HOUSEKEEPING	0	470,050	9.00
10.00	01000	DIETARY	0	141,838	10.00
11.00	01100	CAFETERIA	-173,284	441,651	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	178,800	14.00
15.00	01500	PHARMACY	0	301,746	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20	933,341	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-191,203	222,677	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-552,831	1,893,997	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-115,860	1,792,489	50.00
53.00	05300	ANESTHESIOLOGY	-487,170	42,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-362,644	1,414,962	54.00
54.01	03952	ULTRASOUND	0	201,319	54.01
60.00	06000	LABORATORY	-9,411	1,610,117	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-27,790	827,461	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	169,939	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,827	68.00
69.00	06900	ELECTROCARDIOLOGY	-20,672	17,683	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	322,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	447,891	73.00
76.00	03950	SLEEP LAB	-22,548	155,610	76.00
76.01	03951	DIABETIC EDUCATION	0	4,871	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	283,029	76.02
76.03	03030	WOUNDCARE	0	7,295	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-15	489,826	88.00
88.01	08801	RURAL HEALTH CLINIC II	-292	3,637,354	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	563,283	88.02
91.00	09100	EMERGENCY	-1,101,766	2,830,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-57,201	703,515	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,494,111	35,151,616	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	76,461	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	227,301	194.00
194.01	07951	FOUNDATION	0	120,909	194.01
194.02	07952	CROSSFIT	0	158,907	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,482,365	35,735,194	200.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 8:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	89,208		1.00
	0		0	89,208		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	366,294	248,641		1.00
2.00	DIABETIC EDUCATION	76.01	3,894	977		2.00
3.00	RURAL HEALTH CLINIC II	88.01	2,852	716		3.00
	0		373,040	250,334		
	D - EKG					
1.00	ELECTROCARDIOLOGY	69.00	12,648	3,911		1.00
2.00		0.00	0	0		2.00
	0		12,648	3,911		
	E - RHC ADMITTING					
1.00	PFS & REGISTRATION	5.01	407,630	102,968		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,850	934		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		411,480	103,902		
	F - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	47,960		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	47,960		
	G - CROSSFIT EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,905	2,406		1.00
	0		3,905	2,406		
	H - WORKERS' COMP INS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,656		1.00
	0		0	10,656		
	I - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.02	0	112,658		1.00
2.00		0.00	0	0		2.00
	0		0	112,658		
	J - DOCTORS BLDG COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.02	0	2,065		1.00
2.00	OPERATION OF PLANT	7.00	0	3,756		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,118		3.00
	0		0	20,939		
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	360,253		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	322,704		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	447,891		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	1,130,848		
	L - AMBULANCE SALARY					
1.00	AMBULANCE SERVICES	95.00	57,528	17,570		1.00
	0		57,528	17,570		
	N - DEPRECIATION EXPENSE RECLASS					
1.00	RURAL HEALTH CLINIC I BUILDING	1.01	0	18,281		1.00
2.00	RURAL HEALTH CLINIC III BUILDING	1.02	0	91,085		2.00
3.00	CROSSFIT BUILDING	1.03	0	111,075		3.00
4.00	AMBULANCE/MAINTENANCE GARAGE	1.04	0	14,100		4.00
	0		0	234,541		
	O - BOND RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,879		1.00
	0		0	111,879		
	P - ULTRASOUND SALARIES					
1.00	ULTRASOUND	54.01	134,978	43,517		1.00
	TOTALS		134,978	43,517		

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 8:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	Q - COVID SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.02	12,466	3,520		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		12,466	3,520		
	R - WOUND CARE TIME SHARE COSTS					
1.00	OPERATION OF PLANT	7.00	0	1,441		1.00
2.00	SENIOR LIFE SOLUTIONS	76.02	0	818		2.00
3.00	WOUNDCARE	76.03	0	2,648		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	565		4.00
	TOTALS		0	5,472		
500.00	Grand Total: Increases		1,006,045	2,189,321		500.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 8:56 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.02	0	89,208	12		
	0		0	89,208			
C - CAFETERIA							
1.00	DIETARY	10.00	373,040	250,334	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		373,040	250,334			
D - EKG							
1.00	EMERGENCY	91.00	9,823	3,000	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	2,825	911	0		2.00
	0		12,648	3,911			
E - RHC ADMITTING							
1.00	RURAL HEALTH CLINIC	88.00	59,665	18,074	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	278,992	67,647	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	72,541	18,114	0		3.00
4.00	WOUNDCARE	76.03	282	67	0		4.00
	0		411,480	103,902			
F - LAUNDRY							
1.00	DIETARY	10.00	0	1,632	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,201	0		2.00
3.00	OPERATING ROOM	50.00	0	8,812	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,032	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,825	0		5.00
6.00	SLEEP LAB	76.00	0	674	0		6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	67	0		7.00
8.00	EMERGENCY	91.00	0	10,855	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	269	0		9.00
10.00	CROSSFIT	194.02	0	593	0		10.00
	0		0	47,960			
G - CROSSFIT EMPLOYEE BENEFITS							
1.00	CROSSFIT	194.02	3,905	2,406	0		1.00
	0		3,905	2,406			
H - WORKERS' COMP INS							
1.00	ADMINISTRATIVE & GENERAL	5.02	0	10,656	0		1.00
	0		0	10,656			
I - TELEPHONE EXPENSE							
1.00	RURAL HEALTH CLINIC	88.00	0	3,367	0		1.00
2.00	OPERATION OF PLANT	7.00	0	109,291	0		2.00
	0		0	112,658			
J - DOCTORS BLDG COSTS							
1.00	OPERATION OF PLANT	7.00	0	20,939	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	20,939			
K - MEDICAL SUPPLIES, IMPLANTS & DRUGS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,879	0		1.00
2.00	PHARMACY	15.00	0	447,891	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	12,505	0		3.00
4.00	OPERATING ROOM	50.00	0	613,958	0		4.00
5.00	EMERGENCY	91.00	0	37,887	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	4,728	0		6.00
	0		0	1,130,848			
L - AMBULANCE SALARY							
1.00	EMERGENCY	91.00	57,528	17,570	0		1.00
	0		57,528	17,570			
N - DEPRECIATION EXPENSE RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	234,541	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
	0		0	234,541			
O - BOND RELATED COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.02	0	111,879	14		1.00
	0		0	111,879			
P - ULTRASOUND SALARIES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	134,978	43,517	0		1.00
	TOTALS		134,978	43,517			
Q - COVID SALARIES							
1.00	OPERATING ROOM	50.00	1,295	383	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	60	19	0		2.00
3.00	PHYSICAL THERAPY	66.00	2,904	783	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	5,831	1,414	0		4.00
5.00	EMERGENCY	91.00	157	48	0		5.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 8:56 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
6.00	AMBULANCE SERVICES	95.00	2,219	873	0	6.00
	TOTALS		12,466	3,520		
R - WOUND CARE TIME SHARE COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,472	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	5,472		
500.00	Grand Total: Decreases		1,006,045	2,189,321		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/24/2020 8:56 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	389,780	0	0	0	0	1.00	
2.00	Land Improvements	6,400,384	36,773	0	36,773	0	2.00	
3.00	Buildings and Fixtures	23,761,216	976,251	0	976,251	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	15,028,244	245,593	0	245,593	0	5.00	
6.00	Movable Equipment	9,936,206	1,647,994	0	1,647,994	83,981	6.00	
7.00	HIT designated Assets	3,720,665	109,916	0	109,916	0	7.00	
8.00	Subtotal (sum of lines 1-7)	59,236,495	3,016,527	0	3,016,527	83,981	8.00	
9.00	Reconciling Items	-59,160	-322,094	0	-322,094	0	9.00	
10.00	Total (line 8 minus line 9)	59,295,655	3,338,621	0	3,338,621	83,981	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	389,780	0				1.00	
2.00	Land Improvements	6,437,157	0				2.00	
3.00	Buildings and Fixtures	24,737,467	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	15,273,837	0				5.00	
6.00	Movable Equipment	11,500,219	0				6.00	
7.00	HIT designated Assets	3,830,581	0				7.00	
8.00	Subtotal (sum of lines 1-7)	62,169,041	0				8.00	
9.00	Reconciling Items	-381,254	0				9.00	
10.00	Total (line 8 minus line 9)	62,550,295	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/24/2020 8:56 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	2,650,302	0	1,673,914	0	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	0	0	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	0	0	0	1.02
1.03	CROSSFIT BUILDING	0	0	0	0	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	1,723,780	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,374,082	0	1,673,914	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,324,216				1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0				1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0				1.02
1.03	CROSSFIT BUILDING	0	0				1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,723,780				2.00
3.00	Total (sum of lines 1-2)	0	6,047,996				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/24/2020 8:56 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	43,071,589	0	43,071,589	0.692813	61,803	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	289,068	0	289,068	0.004650	415	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	1,474,468	0	1,474,468	0.023717	2,116	1.02
1.03	CROSSFIT BUILDING	1,650,620	0	1,650,620	0.026551	2,369	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	352,496	0	352,496	0.005670	506	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	15,330,800	0	15,330,800	0.246599	21,999	2.00
3.00	Total (sum of lines 1-2)	62,169,041	0	62,169,041	1.000000	89,208	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	61,803	2,415,761	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	415	18,281	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	2,116	91,085	0	1.02
1.03	CROSSFIT BUILDING	0	0	2,369	111,075	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	506	14,100	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	21,999	1,723,780	0	2.00
3.00	Total (sum of lines 1-2)	0	0	89,208	4,374,082	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,607,627	61,803	0	111,879	4,197,070	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	415	0	0	18,696	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	2,116	0	0	93,201	1.02
1.03	CROSSFIT BUILDING	0	2,369	0	0	113,444	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	506	0	0	14,606	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,999	0	0	1,745,779	2.00
3.00	Total (sum of lines 1-2)	1,607,627	89,208	0	111,879	6,182,796	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 8:56 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		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-66,287	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - RURAL HEALTH CLINIC I BUILDING (chapter 2)			0 RURAL HEALTH CLINIC I BUILDING	1.01	0	1.01
1.02	Investment income - RURAL HEALTH CLINIC III BUILDING (chapter 2)			0 RURAL HEALTH CLINIC III BUILDING	1.02	0	1.02
1.03	Investment income - CROSSFIT BUILDING (chapter 2)			0 CROSSFIT BUILDING	1.03	0	1.03
1.04	Investment income - AMBULANCE/MAINTENANCE GARAGE (chapter 2)			0 AMBULANCE/MAINTENANCE GARAGE	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,386	ADMINISTRATIVE & GENERAL	5.02	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	-2,673,148			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	-173,284	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0 CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - RURAL HEALTH CLINIC I BUILDING			0 RURAL HEALTH CLINIC I BUILDING	1.01	0	26.01
26.02	Depreciation - RURAL HEALTH CLINIC III BUILDING			0 RURAL HEALTH CLINIC III BUILDING	1.02	0	26.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
26.03	Depreciation - CROSSFIT BUILDING			0CROSSFIT BUILDING	1.03	0	26.03
26.04	Depreciation - AMBULANCE/MAINTENANCE GARAGE			0AMBULANCE/MAINTENANCE GARAGE	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-191,203	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-55,067	ADMINISTRATIVE & GENERAL	5.02	0	33.00
33.01	AMBULANCE INCOME	B	-57,201	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-6,901	ADMINISTRATIVE & GENERAL	5.02	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-27,448	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-263,724	ADMINISTRATIVE & GENERAL	5.02	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-11,310	ADMINISTRATIVE & GENERAL	5.02	0	33.05
33.06	PROPERTY TAX	A	-20,156	ADMINISTRATIVE & GENERAL	5.02	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-802,300	ADMINISTRATIVE & GENERAL	5.02	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-16,765	ADMINISTRATIVE & GENERAL	5.02	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,458	ADMINISTRATIVE & GENERAL	5.02	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	11,746	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	11,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.12	TIF EXPENSE NOT RELATED TO THE HOSPI	A	-47,720	ADMINISTRATIVE & GENERAL	5.02	0	33.12
33.14	NON-ALLOWABLE DONATION EXPENSE	A	-97,870	ADMINISTRATIVE & GENERAL	5.02	0	33.14
34.00	MISC EXPENSE - A&G	A	-116	ADMINISTRATIVE & GENERAL	5.02	0	34.00
34.01	MISC EXPENSE - EMPLOYEE BENEFITS	A	-6	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.04	MISC EXPENSE - MED RECORDS	A	-20	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISC EXPENSE - OR	A	-13	OPERATING ROOM	50.00	0	34.05
34.06	MISC EXPENSE - PT	A	-58	PHYSICAL THERAPY	66.00	0	34.06
34.07	MISC EXPENSE - RHC I	A	-15	RURAL HEALTH CLINIC	88.00	0	34.07
34.08	MISC EXPENSE - ANESTHESIA	A	-25	ANESTHESIOLOGY	53.00	0	34.08
34.09	MISC EXPENSE - RHC II	A	-292	RURAL HEALTH CLINIC II	88.01	0	34.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,482,365				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: 14-1301

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

Worksheet A-8-2

Date/Time Prepared:
11/24/2020 8:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	552,831	552,831	0	0	0	1.00
2.00	50.00	OPERATING ROOM	115,847	115,847	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	487,145	487,145	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	362,644	362,644	0	0	0	4.00
5.00	60.00	LABORATORY	9,411	9,411	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	284	284	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	20,672	20,672	0	0	0	7.00
8.00	76.00	SLEEP LAB	22,548	22,548	0	0	0	8.00
9.00	91.00	EMERGENCY	2,431,714	1,101,766	1,329,948	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,003,096	2,673,148	1,329,948			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.00	SLEEP LAB	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	552,831		1.00
2.00	50.00	OPERATING ROOM	0	0	0	115,847		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	487,145		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	362,644		4.00
5.00	60.00	LABORATORY	0	0	0	9,411		5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	284		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,672		7.00
8.00	76.00	SLEEP LAB	0	0	0	22,548		8.00
9.00	91.00	EMERGENCY	0	0	0	1,101,766		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,673,148		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 8:56 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					31	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	149.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	85.53	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.77	42.77	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					12,744	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					12,744	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					12,744	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					12,744	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,326	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,326	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					179	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,505	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,505	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 8:56 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	85.53	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						12,744	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,505	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						14,249	63.00
64.00	Total cost of outside supplier services (from your records)						10,728	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,326	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						179	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,505	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						179	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						179	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 8:56 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					67	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	231.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.89	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.95	38.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					17,993	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					17,993	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					17,993	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					28,040	22.00
23.00	Total salary equivalency (see instructions)					28,040	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,610	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,610	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					387	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,997	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,997	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/24/2020 8:56 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.89	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						28,040	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,997	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						31,037	63.00
64.00	Total cost of outside supplier services (from your records)						14,983	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,610	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						387	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,997	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						387	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						387	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,197,070	4,197,070			1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	18,696	0	18,696		1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	93,201	0	0	93,201	1.02
1.03	00103	CROSSFIT BUILDING	113,444	0	0	0	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,606	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,745,779				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	227,593	5,444	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,551,672	100,431	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	5,847,405	339,246	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	567,542	12,897	0	0	6.00
7.00	00700	OPERATION OF PLANT	230,143	814,445	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,960	16,280	0	0	8.00
9.00	00900	HOUSEKEEPING	470,050	42,181	0	0	9.00
10.00	01000	DIETARY	141,838	129,080	0	0	10.00
11.00	01100	CAFETERIA	441,651	59,572	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	178,800	86,529	0	0	14.00
15.00	01500	PHARMACY	301,746	29,971	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	933,341	79,816	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	222,677	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,893,997	476,414	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,792,489	408,226	0	0	50.00
53.00	05300	ANESTHESIOLOGY	42,056	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,414,962	193,621	0	0	54.00
54.01	03952	ULTRASOUND	201,319	8,140	0	0	54.01
60.00	06000	LABORATORY	1,610,117	123,372	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	827,461	224,490	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,939	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,827	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,683	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,253	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	322,704	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	447,891	0	0	0	73.00
76.00	03950	SLEEP LAB	155,610	19,875	0	0	76.00
76.01	03951	DIABETIC EDUCATION	4,871	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	283,029	0	0	0	76.02
76.03	03030	WOUND CARE	7,295	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	489,826	0	18,696	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,637,354	613,634	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	563,283	0	0	75,427	88.02
91.00	09100	EMERGENCY	2,830,921	338,664	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	703,515	40,648	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,151,616	4,162,976	18,696	75,427	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,968	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,461	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	227,301	12,052	0	17,774	194.00
194.01	07951	FOUNDATION	120,909	5,074	0	0	194.01
194.02	07952	CROSSFIT	158,907	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0		0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,735,194	4,197,070	18,696	93,201	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	Subtotal	
			AMBULANCE/MAIN TENANCE GARAGE	MVBLE EQUIP				
			1.04	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,606					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,745,779				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	233,037			4.00
5.01	00540	PFS & REGISTRATION	0	0	14,148	1,666,251		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	584,051	40,149	0	6,810,851	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	17,382	4,570	0	602,391	6.00
7.00	00700	OPERATION OF PLANT	4,231	128,876	0	0	1,177,695	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	64,240	8.00
9.00	00900	HOUSEKEEPING	195	5,124	4,572	0	522,122	9.00
10.00	01000	DIETARY	0	37,876	1,341	0	310,135	10.00
11.00	01100	CAFETERIA	0	0	5,746	0	506,969	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,880	2,020	0	269,229	14.00
15.00	01500	PHARMACY	0	44,279	2,947	0	378,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,635	9,303	0	1,033,095	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	3,073	0	225,750	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	89,860	20,341	154,684	2,635,296	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	170,615	9,176	260,670	2,641,176	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	49,372	91,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	356,903	9,734	243,968	2,219,188	54.00
54.01	03952	ULTRASOUND	0	40,652	2,118	27,479	279,708	54.01
60.00	06000	LABORATORY	0	59,021	9,506	301,572	2,103,588	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	6,005	9,688	72,371	1,140,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,065	10,435	182,439	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	212	2,569	32,608	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	198	16,903	34,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22,627	382,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,712	337,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	89,131	537,022	73.00
76.00	03950	SLEEP LAB	0	1,889	1,865	12,680	191,919	76.00
76.01	03951	DIABETIC EDUCATION	0	0	61	515	5,447	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	251	1,856	285,136	76.02
76.03	03030	WOUNDCARE	0	0	37	857	8,189	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	4,846	4,833	10,960	529,161	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	30,520	40,292	80,479	4,402,279	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	17,744	6,072	12,846	675,372	88.02
91.00	09100	EMERGENCY	0	20,510	16,416	229,367	3,435,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	10,180	99,401	7,509	50,198	911,451	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,606	1,728,069	228,243	1,666,251	34,963,800	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	16,968	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,589	60	0	80,110	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	5,724	2,201	0	265,052	194.00
194.01	07951	FOUNDATION	0	0	1,086	0	127,069	194.01
194.02	07952	CROSSFIT	0	8,397	1,447	0	282,195	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,606	1,745,779	233,037	1,666,251	35,735,194	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL	6,810,851					5.02
6.00	00600	MAINTENANCE & REPAIRS	141,846	744,237				6.00
7.00	00700	OPERATION OF PLANT	277,313	154,140	1,609,148			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,127	2,898	8,958	91,223		8.00
9.00	00900	HOUSEKEEPING	122,945	7,931	23,208	0	676,206	9.00
10.00	01000	DIETARY	73,028	22,976	71,021	3,102	25,949	10.00
11.00	01100	CAFETERIA	119,376	10,603	32,777	0	11,975	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,396	15,402	47,609	0	17,395	14.00
15.00	01500	PHARMACY	89,230	5,335	16,490	0	6,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	243,264	14,207	43,916	0	16,045	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	53,158	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	620,536	84,799	262,127	34,630	95,772	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	621,920	72,662	224,610	16,760	82,065	50.00
53.00	05300	ANESTHESIOLOGY	21,529	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	522,554	34,464	106,532	9,566	38,923	54.00
54.01	03952	ULTRASOUND	65,863	1,449	4,479	0	1,636	54.01
60.00	06000	LABORATORY	495,334	21,960	67,880	0	24,801	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	268,440	39,958	123,517	3,472	45,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,959	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,678	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,191	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,157	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,453	0	0	0	0	73.00
76.00	03950	SLEEP LAB	45,191	3,538	10,935	1,287	3,995	76.00
76.01	03951	DIABETIC EDUCATION	1,283	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	67,141	0	0	0	0	76.02
76.03	03030	WOUND CARE	1,928	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	124,602	5,824	0	0	6,577	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,036,615	109,224	337,629	127	123,357	88.01
88.02	08802	RURAL HEALTH CLINIC III	159,031	0	0	0	50,325	88.02
91.00	09100	EMERGENCY	809,050	60,281	186,336	20,636	68,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	214,620	29,308	22,365	512	8,171	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,629,210	696,959	1,590,389	90,092	626,221	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,995	3,020	9,336	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,864	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	62,412	2,145	6,631	0	2,423	194.00
194.01	07951	FOUNDATION	29,921	903	2,792	0	1,020	194.01
194.02	07952	CROSSFIT	66,449	41,210	0	1,131	46,542	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)	6,810,851	744,237	1,609,148	91,223	676,206	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	506,211					10.00
11.00	01100	CAFETERIA	0	681,700				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,406	429,437			14.00
15.00	01500	PHARMACY	0	9,159	414	505,596		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,611	1,323	0	1,415,461	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	506,211	110,211	8,747	0	259,454	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	46,249	23,785	0	171,554	50.00
53.00	05300	ANESTHESIOLOGY	0	5,938	2,760	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,973	10,409	0	68,367	54.00
54.01	03952	ULTRASOUND	0	8,505	2,510	0	10,758	54.01
60.00	06000	LABORATORY	0	59,937	130,444	0	211,328	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	44,990	2,982	0	62,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,102	13	0	1,415	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,409	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	805	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	90,762	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	81,302	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	505,596	0	73.00
76.00	03950	SLEEP LAB	0	8,404	813	0	11,465	76.00
76.01	03951	DIABETIC EDUCATION	0	252	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	5,133	994	0	0	76.02
76.03	03030	WOUNDCARE	0	453	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	10,021	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	111,469	36,378	0	126,967	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	8,265	0	0	88.02
91.00	09100	EMERGENCY	0	99,895	11,330	0	455,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	14,544	2,341	0	36,094	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	506,211	665,445	425,593	505,596	1,415,461	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	111	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	5,687	1,062	0	0	194.00
194.01	07951	FOUNDATION	0	3,019	91	0	0	194.01
194.02	07952	CROSSFIT	0	7,549	2,580	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	506,211	681,700	429,437	505,596	1,415,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 8:56 am

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
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
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	278,908				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,617,783	-150,244	4,467,539	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,900,781	0	3,900,781	50.00
53.00	05300	ANESTHESIOLOGY	278,908	400,563	0	400,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,059,976	0	3,059,976	54.00
54.01	03952	ULTRASOUND	0	374,908	0	374,908	54.01
60.00	06000	LABORATORY	0	3,115,272	0	3,115,272	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	150,244	150,244	64.00
66.00	06600	PHYSICAL THERAPY	0	1,730,783	0	1,730,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,928	0	234,928	67.00
68.00	06800	SPEECH PATHOLOGY	0	41,695	0	41,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,780	0	43,780	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	563,799	0	563,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	498,170	0	498,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,169,071	0	1,169,071	73.00
76.00	03950	SLEEP LAB	0	277,547	0	277,547	76.00
76.01	03951	DIABETIC EDUCATION	0	6,982	0	6,982	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	358,404	0	358,404	76.02
76.03	03030	WOUNDCARE	0	10,570	0	10,570	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	676,185	0	676,185	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,284,045	0	6,284,045	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	892,993	0	892,993	88.02
91.00	09100	EMERGENCY	0	5,147,266	0	5,147,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,239,406	0	1,239,406	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,908	34,644,907	0	34,644,907	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,319	0	33,319	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	99,085	0	99,085	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	345,412	0	345,412	194.00
194.01	07951	FOUNDATION	0	164,815	0	164,815	194.01
194.02	07952	CROSSFIT	0	447,656	0	447,656	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)	278,908	35,735,194	0	35,735,194	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,444	0	0	4.00
5.01	00540	PFS & REGISTRATION	0	100,431	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	24,162	339,246	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	12,897	0	0	6.00
7.00	00700	OPERATION OF PLANT	11,746	814,445	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,280	0	0	8.00
9.00	00900	HOUSEKEEPING	0	42,181	0	0	9.00
10.00	01000	DIETARY	0	129,080	0	0	10.00
11.00	01100	CAFETERIA	0	59,572	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	86,529	0	0	14.00
15.00	01500	PHARMACY	0	29,971	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,816	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	7,681	476,414	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	141,372	408,226	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,425	193,621	0	0	54.00
54.01	03952	ULTRASOUND	0	8,140	0	0	54.01
60.00	06000	LABORATORY	0	123,372	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	224,490	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	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
76.00	03950	SLEEP LAB	556	19,875	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	10,157	0	0	0	76.02
76.03	03030	WOUNDCARE	1,571	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	18,696	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	613,634	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	75,427	88.02
91.00	09100	EMERGENCY	0	338,664	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	40,648	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,670	4,162,976	18,696	75,427	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,968	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,335	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	12,052	0	17,774	194.00
194.01	07951	FOUNDATION	0	5,074	0	0	194.01
194.02	07952	CROSSFIT	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	376,005	4,197,070	18,696	93,201	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	
			AMBULANCE/MAIN TENANCE GARAGE	MVBLE EQUIP				
			1.04	2.00				
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,444	5,444		4.00
5.01	00540	PFS & REGISTRATION	0	0	100,431	330	100,761	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	584,051	947,459	937	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	17,382	30,279	107	0	6.00
7.00	00700	OPERATION OF PLANT	4,231	128,876	959,298	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	16,280	0	0	8.00
9.00	00900	HOUSEKEEPING	195	5,124	47,500	107	0	9.00
10.00	01000	DIETARY	0	37,876	166,956	31	0	10.00
11.00	01100	CAFETERIA	0	0	59,572	134	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,880	88,409	47	0	14.00
15.00	01500	PHARMACY	0	44,279	74,250	69	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,635	90,451	217	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	72	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	89,860	573,955	475	9,352	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	170,615	720,213	214	15,760	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,985	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	356,903	690,949	227	14,750	54.00
54.01	03952	ULTRASOUND	0	40,652	48,792	49	1,661	54.01
60.00	06000	LABORATORY	0	59,021	182,393	222	18,254	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	6,005	230,495	226	4,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	48	631	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	155	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5	1,022	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,389	73.00
76.00	03950	SLEEP LAB	0	1,889	22,320	44	767	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	1	31	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	10,157	6	112	76.02
76.03	03030	WOUNDCARE	0	0	1,571	1	52	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,846	23,542	113	663	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	30,520	644,154	946	4,866	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	17,744	93,171	142	777	88.02
91.00	09100	EMERGENCY	0	20,510	359,174	383	13,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	10,180	99,401	150,229	175	3,035	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,606	1,728,069	6,337,444	5,333	100,761	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,968	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,589	41,924	1	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	5,724	35,550	51	0	194.00
194.01	07951	FOUNDATION	0	0	5,074	25	0	194.01
194.02	07952	CROSSFIT	0	8,397	121,841	34	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,606	1,745,779	6,558,801	5,444	100,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL	948,396				5.02
6.00	00600	MAINTENANCE & REPAIRS	19,752	50,138			6.00
7.00	00700	OPERATION OF PLANT	38,615	10,386	1,008,299		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,106	195	5,613	24,194	8.00
9.00	00900	HOUSEKEEPING	17,120	534	14,543	0	79,804
10.00	01000	DIETARY	10,169	1,548	44,502	823	3,062
11.00	01100	CAFETERIA	16,623	714	20,538	0	1,413
14.00	01400	CENTRAL SERVICES & SUPPLY	8,828	1,038	29,832	0	2,053
15.00	01500	PHARMACY	12,425	359	10,333	0	711
16.00	01600	MEDICAL RECORDS & LIBRARY	33,874	957	27,538	0	1,894
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,402	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	86,409	5,713	164,250	9,184	11,303
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	86,602	4,895	140,742	4,445	9,685
53.00	05300	ANESTHESIOLOGY	2,998	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,765	2,322	66,753	2,537	4,594
54.01	03952	ULTRASOUND	9,171	98	2,806	0	193
60.00	06000	LABORATORY	68,975	1,479	42,534	0	2,927
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	37,380	2,692	77,396	921	5,326
67.00	06700	OCCUPATIONAL THERAPY	5,982	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	1,069	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,141	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,554	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,064	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	17,608	0	0	0	0
76.00	03950	SLEEP LAB	6,293	238	6,852	341	472
76.01	03951	DIABETIC EDUCATION	179	0	0	0	0
76.02	03020	SENIOR LIFE SOLUTIONS	9,349	0	0	0	0
76.03	03030	WOUNDCARE	269	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,351	392	0	0	776
88.01	08801	RURAL HEALTH CLINIC II	144,340	7,358	211,560	34	14,558
88.02	08802	RURAL HEALTH CLINIC III	22,145	0	0	0	5,939
91.00	09100	EMERGENCY	112,659	4,061	116,759	5,473	8,035
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	29,886	1,974	14,014	136	964
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	923,103	46,953	996,545	23,894	73,905
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	556	203	5,850	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,627	0	0	0	0
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	8,691	145	4,155	0	286
194.01	07951	FOUNDATION	4,166	61	1,749	0	120
194.02	07952	CROSSFIT	9,253	2,776	0	300	5,493
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	948,396	50,138	1,008,299	24,194	79,804

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	227,091					10.00
11.00	01100	CAFETERIA	0	98,994				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,382	132,589			14.00
15.00	01500	PHARMACY	0	1,330	128	99,605		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,237	409	0	164,557	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	227,091	16,004	2,701	0	30,163	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,716	7,344	0	19,944	50.00
53.00	05300	ANESTHESIOLOGY	0	862	852	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,257	3,214	0	7,948	54.00
54.01	03952	ULTRASOUND	0	1,235	775	0	1,251	54.01
60.00	06000	LABORATORY	0	8,704	40,272	0	24,568	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	6,533	921	0	7,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,177	4	0	165	67.00
68.00	06800	SPEECH PATHOLOGY	0	205	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	117	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	28,023	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,102	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	99,605	0	73.00
76.00	03950	SLEEP LAB	0	1,220	251	0	1,333	76.00
76.01	03951	DIABETIC EDUCATION	0	37	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	745	307	0	0	76.02
76.03	03030	WOUNDCARE	0	66	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,094	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	16,189	11,232	0	14,761	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,552	0	0	88.02
91.00	09100	EMERGENCY	0	14,506	3,498	0	52,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,112	723	0	4,196	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,091	96,634	131,402	99,605	164,557	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	34	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	826	328	0	0	194.00
194.01	07951	FOUNDATION	0	438	28	0	0	194.01
194.02	07952	CROSSFIT	0	1,096	797	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)	227,091	98,994	132,589	99,605	164,557	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 8:56 am

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
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
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	7,474				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,136,600	0	1,136,600	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,016,560	0	1,016,560	50.00
53.00	05300	ANESTHESIOLOGY		7,697	0	7,697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		873,316	0	873,316	54.00
54.01	03952	ULTRASOUND		66,031	0	66,031	54.01
60.00	06000	LABORATORY		390,328	0	390,328	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY		373,506	0	373,506	66.00
67.00	06700	OCCUPATIONAL THERAPY		8,007	0	8,007	67.00
68.00	06800	SPEECH PATHOLOGY		1,434	0	1,434	68.00
69.00	06900	ELECTROCARDIOLOGY		2,285	0	2,285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		41,945	0	41,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		37,055	0	37,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		122,602	0	122,602	73.00
76.00	03950	SLEEP LAB		40,131	0	40,131	76.00
76.01	03951	DIABETIC EDUCATION		248	0	248	76.01
76.02	03020	SENIOR LIFE SOLUTIONS		20,676	0	20,676	76.02
76.03	03030	WOUND CARE		1,959	0	1,959	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		45,931	0	45,931	88.00
88.01	08801	RURAL HEALTH CLINIC II		1,069,998	0	1,069,998	88.01
88.02	08802	RURAL HEALTH CLINIC III		124,726	0	124,726	88.02
91.00	09100	EMERGENCY		691,402	0	691,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		207,444	0	207,444	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,279,881	0	6,279,881	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,577	0	23,577	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		44,586	0	44,586	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO		50,032	0	50,032	194.00
194.01	07951	FOUNDATION		11,661	0	11,661	194.01
194.02	07952	CROSSFIT		141,590	0	141,590	194.02
200.00		Cross Foot Adjustments	7,474	7,474	0	7,474	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,474	6,558,801	0	6,558,801	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	RURAL HEALTH CLINIC I BUILDING (SQUARE FEET)	RURAL HEALTH CLINIC III BUILDING (SQUARE FEET)	CROSSFIT BUILDING (SQUARE FEET)	AMBULANCE/MAIN TENANCE GARAGE (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,402					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	619				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	0	5,852			1.02
1.03	00103	CROSSFIT BUILDING	0	0	0	4,380		1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	3,366	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103	0	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,900	0	0	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	6,418	0	0	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	244	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,408	0	0	0	975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	798	0	0	0	45	9.00
10.00	01000	DIETARY	2,442	0	0	0	0	10.00
11.00	01100	CAFETERIA	1,127	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	0	0	0	0	14.00
15.00	01500	PHARMACY	567	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	0	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	9,013	0	0	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,723	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,663	0	0	0	0	54.00
54.01	03952	ULTRASOUND	154	0	0	0	0	54.01
60.00	06000	LABORATORY	2,334	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	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
76.00	03950	SLEEP LAB	376	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	619	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,609	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,736	0	0	88.02
91.00	09100	EMERGENCY	6,407	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	769	0	0	0	2,346	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,757	619	4,736	0	3,366	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	0	1,116	0	0	194.00
194.01	07951	FOUNDATION	96	0	0	0	0	194.01
194.02	07952	CROSSFIT	0	0	0	4,380	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)	4,197,070	18,696	93,201	113,444	14,606	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	52.858492	30.203554	15.926350	25.900457	4.339275	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PFS & REGISTRATION (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		MVBLE EQUIP (DOLLAR VALUE)					
		2.00	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,723,780				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,854,355			4.00
5.01	00540	PFS & REGISTRATION	0	901,820	79,696,535		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	576,692	2,559,243	0	-6,810,851	5.02
6.00	00600	MAINTENANCE & REPAIRS	17,163	291,321	0	0	6.00
7.00	00700	OPERATION OF PLANT	127,252	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	5,059	291,445	0	0	9.00
10.00	01000	DIETARY	37,399	85,459	0	0	10.00
11.00	01100	CAFETERIA	0	366,294	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,856	128,743	0	0	14.00
15.00	01500	PHARMACY	43,721	187,876	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,501	593,028	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	195,901	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	88,728	1,296,576	7,398,676	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,465	584,892	12,468,068	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,361,523	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,406	620,478	11,669,189	0	54.00
54.01	03952	ULTRASOUND	40,140	134,978	1,314,333	0	54.01
60.00	06000	LABORATORY	58,277	605,972	14,422,853	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	5,929	617,533	3,461,545	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,644	499,110	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,483	122,867	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,648	808,500	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,082,263	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	703,669	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,263,193	0	73.00
76.00	03950	SLEEP LAB	1,865	118,899	606,485	0	76.00
76.01	03951	DIABETIC EDUCATION	0	3,894	24,615	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	15,986	88,790	0	76.02
76.03	03030	WOUNDCARE	0	2,345	40,974	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,785	308,098	524,238	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	30,135	2,568,168	3,849,358	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	17,520	387,033	614,459	0	88.02
91.00	09100	EMERGENCY	20,252	1,046,407	10,970,818	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	98,148	478,629	2,401,009	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,706,293	14,548,793	79,696,535	-6,810,851	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,544	3,850	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	5,652	140,267	0	0	194.00
194.01	07951	FOUNDATION	0	69,210	0	0	194.01
194.02	07952	CROSSFIT	8,291	92,235	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)	1,745,779	233,037	1,666,251	6,810,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.012762	0.015688	0.020907	0.235471	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		5,444	100,761	948,396	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000366	0.001264	0.032789	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS	79,102				6.00
7.00	00700	OPERATION OF PLANT	16,383	55,329			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	308	75,400		8.00
9.00	00900	HOUSEKEEPING	843	798	0	63,637	9.00
10.00	01000	DIETARY	2,442	2,442	2,564	13,502	10.00
11.00	01100	CAFETERIA	1,127	1,127	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	1,637	0	1,637	14.00
15.00	01500	PHARMACY	567	567	0	567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	1,510	0	1,510	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,013	9,013	28,622	9,013	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,723	7,723	13,853	7,723	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,663	3,663	7,907	3,663	54.00
54.01	03952	ULTRASOUND	154	154	0	154	54.01
60.00	06000	LABORATORY	2,334	2,334	0	2,334	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	4,247	2,870	4,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	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
76.00	03950	SLEEP LAB	376	376	1,064	376	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	619	0	0	619	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,609	11,609	105	11,609	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	4,736	88.02
91.00	09100	EMERGENCY	6,407	6,407	17,057	6,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,115	769	423	769	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,077	54,684	74,465	58,933	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	321	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	228	0	228	194.00
194.01	07951	FOUNDATION	96	96	0	96	194.01
194.02	07952	CROSSFIT	4,380	0	935	4,380	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)	744,237	1,609,148	91,223	676,206	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.408574	29.083266	1.209854	37.491557	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,138	1,008,299	24,194	79,804	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.633840	18.223698	0.320875	16.819064	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	13,546					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	326	1,704,528				14.00
15.00	01500	PHARMACY	182	1,644	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,264	5,252	0	10,000		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,190	34,720	0	1,833	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	919	94,407	0	1,212	0	50.00
53.00	05300	ANESTHESIOLOGY	118	10,954	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	993	41,317	0	483	0	54.00
54.01	03952	ULTRASOUND	169	9,962	0	76	0	54.01
60.00	06000	LABORATORY	1,191	517,755	0	1,493	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	894	11,836	0	440	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	161	53	0	10	0	67.00
68.00	06800	SPEECH PATHOLOGY	28	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360,253	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	322,704	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
76.00	03950	SLEEP LAB	167	3,227	0	81	0	76.00
76.01	03951	DIABETIC EDUCATION	5	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	102	3,944	0	0	0	76.02
76.03	03030	WOUNDCARE	9	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	39,775	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,215	144,393	0	897	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	32,807	0	0	0	88.02
91.00	09100	EMERGENCY	1,985	44,973	0	3,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	289	9,293	0	255	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,223	1,689,269	100	10,000	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	441	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	113	4,214	0	0	0	194.00
194.01	07951	FOUNDATION	60	363	0	0	0	194.01
194.02	07952	CROSSFIT	150	10,241	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)	681,700	429,437	505,596	1,415,461	278,908	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	50.324819	0.251939	5,055.960000	141.546100	2,789.080000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,994	132,589	99,605	164,557	7,474	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.307988	0.077786	996.050000	16.455700	74.740000	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: 14-1301

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

Worksheet B-2

Date/Time Prepared:
11/24/2020 8:56 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		ADULTS & PEDIATRICS		1	30.00	-150,244 7.00
8.00		OTHER OUTPATIENT SERVICES		1	64.00	150,244 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 8:56 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,467,539		4,467,539	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,900,781		3,900,781	0	0	50.00
53.00	05300	ANESTHESIOLOGY	400,563		400,563	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,059,976		3,059,976	0	0	54.00
54.01	03952	ULTRASOUND	374,908		374,908	0	0	54.01
60.00	06000	LABORATORY	3,115,272		3,115,272	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	150,244		150,244	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,730,783	0	1,730,783	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,928	0	234,928	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	41,695	0	41,695	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43,780		43,780	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	563,799		563,799	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	498,170		498,170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,169,071		1,169,071	0	0	73.00
76.00	03950	SLEEP LAB	277,547		277,547	0	0	76.00
76.01	03951	DIABETIC EDUCATION	6,982		6,982	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	358,404		358,404	0	0	76.02
76.03	03030	WOUND CARE	10,570		10,570	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	676,185		676,185	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,284,045		6,284,045	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	892,993		892,993	0	0	88.02
91.00	09100	EMERGENCY	5,147,266		5,147,266	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	647,420		647,420		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,239,406		1,239,406	0	0	95.00
200.00		Subtotal (see instructions)	35,292,327	0	35,292,327	0	0	200.00
201.00		Less Observation Beds	647,420		647,420		0	201.00
202.00		Total (see instructions)	34,644,907	0	34,644,907	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 8:56 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,424,067		6,424,067		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	158,802	12,309,266	12,468,068	0.312862	0.000000
53.00	05300	ANESTHESIOLOGY	34,060	2,327,463	2,361,523	0.169621	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,854	11,515,335	11,669,189	0.262227	0.000000
54.01	03952	ULTRASOUND	73,829	1,240,504	1,314,333	0.285246	0.000000
60.00	06000	LABORATORY	507,817	13,915,036	14,422,853	0.215996	0.000000
64.00	06400	INTRAVENOUS THERAPY	2,866	471,307	474,173	0.316855	0.000000
66.00	06600	PHYSICAL THERAPY	310,731	3,150,814	3,461,545	0.500003	0.000000
67.00	06700	OCCUPATIONAL THERAPY	268,710	230,400	499,110	0.470694	0.000000
68.00	06800	SPEECH PATHOLOGY	47,327	75,540	122,867	0.339351	0.000000
69.00	06900	ELECTROCARDIOLOGY	15,800	792,700	808,500	0.054150	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,249	903,014	1,082,263	0.520945	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,032	663,637	703,669	0.707961	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	952,204	3,310,989	4,263,193	0.274224	0.000000
76.00	03950	SLEEP LAB	0	606,485	606,485	0.457632	0.000000
76.01	03951	DIABETIC EDUCATION	0	24,615	24,615	0.283648	0.000000
76.02	03020	SENIOR LIFE SOLUTIONS	0	88,790	88,790	4.036536	0.000000
76.03	03030	WOUNDCARE	0	40,974	40,974	0.257968	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	524,238	524,238		
88.01	08801	RURAL HEALTH CLINIC II	0	3,849,358	3,849,358		
88.02	08802	RURAL HEALTH CLINIC III	0	614,459	614,459		
91.00	09100	EMERGENCY	0	10,970,818	10,970,818	0.469178	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	500,436	500,436	1.293712	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,401,009	2,401,009	0.516202	0.000000
200.00		Subtotal (see instructions)	9,169,348	70,527,187	79,696,535		
201.00		Less Observation Beds					
202.00		Total (see instructions)	9,169,348	70,527,187	79,696,535		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03952 ULTRASOUND	0.000000			54.01
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
76.02	03020 SENIOR LIFE SOLUTIONS	0.000000			76.02
76.03	03030 WOUNDCARE	0.000000			76.03
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
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,016,560	12,468,068	0.081533	70,685	5,763	50.00
53.00	05300 ANESTHESIOLOGY	7,697	2,361,523	0.003259	10,128	33	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	873,316	11,669,189	0.074839	31,857	2,384	54.00
54.01	03952 ULTRASOUND	66,031	1,314,333	0.050239	24,240	1,218	54.01
60.00	06000 LABORATORY	390,328	14,422,853	0.027063	101,237	2,740	60.00
64.00	06400 INTRAVENOUS THERAPY	0	474,173	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	373,506	3,461,545	0.107902	17,736	1,914	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,007	499,110	0.016043	9,871	158	67.00
68.00	06800 SPEECH PATHOLOGY	1,434	122,867	0.011671	7,904	92	68.00
69.00	06900 ELECTROCARDIOLOGY	2,285	808,500	0.002826	7,110	20	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	41,945	1,082,263	0.038757	43,043	1,668	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,055	703,669	0.052660	18,447	971	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	122,602	4,263,193	0.028758	107,514	3,092	73.00
76.00	03950 SLEEP LAB	40,131	606,485	0.066170	0	0	76.00
76.01	03951 DIABETIC EDUCATION	248	24,615	0.010075	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	20,676	88,790	0.232864	0	0	76.02
76.03	03030 WOUNDCARE	1,959	40,974	0.047811	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	45,931	524,238	0.087615	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,069,998	3,849,358	0.277968	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	124,726	614,459	0.202985	0	0	88.02
91.00	09100 EMERGENCY	691,402	10,970,818	0.063022	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	164,712	500,436	0.329137	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	5,100,549	70,871,459		449,772	20,053	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description			Title XVIII		Hospital		Cost
			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	278,908	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	03952	ULTRASOUND	0	0	0	0	0 54.01
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
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
76.00	03950	SLEEP LAB	0	0	0	0	0 76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0 76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	0 76.02
76.03	03030	WOUNDCARE	0	0	0	0	0 76.03
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
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	278,908	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1301		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 8:56 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,468,068	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	278,908	0	2,361,523	0.118105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,669,189	0.000000	54.00
54.01	03952	ULTRASOUND	0	0	0	1,314,333	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	14,422,853	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	474,173	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,461,545	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	499,110	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	122,867	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	808,500	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,082,263	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	703,669	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,263,193	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	606,485	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	24,615	0.000000	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	88,790	0.000000	76.02
76.03	03030	WOUNDCARE	0	0	0	40,974	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	524,238	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,849,358	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	614,459	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	10,970,818	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	500,436	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	278,908	0	70,871,459		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

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

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	70,685	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,128	1,196	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,857	0	0	0	54.00
54.01	03952	ULTRASOUND	0.000000	24,240	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	101,237	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	17,736	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,871	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,904	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,110	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	43,043	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	18,447	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	107,514	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0.000000	0	0	0	0	76.03
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
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		449,772	1,196	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/24/2020 8:56 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.312862	0	3,444,389	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.169621	0	673,356	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.262227	0	2,602,868	0	0	54.00
54.01	03952	ULTRASOUND	0.285246	0	305,442	0	0	54.01
60.00	06000	LABORATORY	0.215996	0	3,517,136	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.316855	0	184,107	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.500003	0	869,609	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.470694	0	60,887	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.339351	0	36,891	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054150	0	216,358	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520945	0	289,998	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.707961	0	218,688	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274224	0	1,669,599	23,248	0	73.00
76.00	03950	SLEEP LAB	0.457632	0	129,186	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.283648	0	507	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	4.036536	0	72,375	0	0	76.02
76.03	03030	WOUNDCARE	0.257968	0	8,902	0	0	76.03
	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
91.00	09100	EMERGENCY	0.469178	0	2,266,843	20,826	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.293712	0	200,849	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.516202		0			95.00
200.00		Subtotal (see instructions)		0	16,767,990	44,074	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	16,767,990	44,074	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/24/2020 8:56 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,077,618	0		50.00
53.00	05300	ANESTHESIOLOGY	114,215	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,542	0		54.00
54.01	03952	ULTRASOUND	87,126	0		54.01
60.00	06000	LABORATORY	759,687	0		60.00
64.00	06400	INTRAVENOUS THERAPY	58,335	0		64.00
66.00	06600	PHYSICAL THERAPY	434,807	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,659	0		67.00
68.00	06800	SPEECH PATHOLOGY	12,519	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,716	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,073	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154,823	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	457,844	6,375		73.00
76.00	03950	SLEEP LAB	59,120	0		76.00
76.01	03951	DIABETIC EDUCATION	144	0		76.01
76.02	03020	SENIOR LIFE SOLUTIONS	292,144	0		76.02
76.03	03030	WOUNDCARE	2,296	0		76.03
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
91.00	09100	EMERGENCY	1,063,553	9,771		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,841	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,708,062	16,146		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,708,062	16,146		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 8:56 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,995	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		491	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)		261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		780	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)		292	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		414	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)		18	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		153	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)		366	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)		263	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		4,467,539	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)		65,077	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)		2,829	25.00
26.00	Total swing-bed cost (see instructions)		3,085,436	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,382,103	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,382,103	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,814.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		430,674	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)		430,674	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		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)					142,515	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					573,189	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,030,239	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					740,308	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,770,547	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)					230	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,814.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					647,420	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Title XVIII		Hospital		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	1,136,600	4,467,539	0.254413	647,420	164,712	90.00
91.00	Nursing School cost	0	4,467,539	0.000000	647,420	0	91.00
92.00	Allied health cost	0	4,467,539	0.000000	647,420	0	92.00
93.00	All other Medical Education	0	4,467,539	0.000000	647,420	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 8:56 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		705,202		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.312862	70,685	22,115	50.00
53.00	05300 ANESTHESIOLOGY	0.169621	10,128	1,718	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262227	31,857	8,354	54.00
54.01	03952 ULTRASOUND	0.285246	24,240	6,914	54.01
60.00	06000 LABORATORY	0.215996	101,237	21,867	60.00
64.00	06400 INTRAVENOUS THERAPY	0.316855	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.500003	17,736	8,868	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.470694	9,871	4,646	67.00
68.00	06800 SPEECH PATHOLOGY	0.339351	7,904	2,682	68.00
69.00	06900 ELECTROCARDIOLOGY	0.054150	7,110	385	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520945	43,043	22,423	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.707961	18,447	13,060	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274224	107,514	29,483	73.00
76.00	03950 SLEEP LAB	0.457632	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.283648	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	4.036536	0	0	76.02
76.03	03030 WOUNDCARE	0.257968	0	0	76.03
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
91.00	09100 EMERGENCY	0.469178	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.293712	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		449,772	142,515	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)		449,772		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301 Component CCN: 14-Z301	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 8:56 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.312862	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.169621	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262227	35,825	9,394	54.00
54.01	03952 ULTRASOUND	0.285246	6,934	1,978	54.01
60.00	06000 LABORATORY	0.215996	205,227	44,328	60.00
64.00	06400 INTRAVENOUS THERAPY	0.316855	1,433	454	64.00
66.00	06600 PHYSICAL THERAPY	0.500003	146,877	73,439	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.470694	124,704	58,697	67.00
68.00	06800 SPEECH PATHOLOGY	0.339351	16,523	5,607	68.00
69.00	06900 ELECTROCARDIOLOGY	0.054150	2,370	128	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520945	73,852	38,473	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.707961	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274224	531,300	145,695	73.00
76.00	03950 SLEEP LAB	0.457632	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.283648	0	0	76.01
76.02	03020 SENIOR LIFE SOLUTIONS	4.036536	0	0	76.02
76.03	03030 WOUNDCARE	0.257968	0	0	76.03
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
91.00	09100 EMERGENCY	0.469178	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.293712	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,145,045	378,193	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,145,045		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/24/2020 8:56 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,724,208	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,724,208	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,781,450	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		27,701	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,621,738	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)		3,132,011	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)		3,132,011	30.00
31.00	Primary payer payments		1,705	31.00
32.00	Subtotal (line 30 minus line 31)		3,130,306	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)		310,693	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		201,950	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		162,321	36.00
37.00	Subtotal (see instructions)		3,332,256	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,332,256	40.00
40.01	Sequestration adjustment (see instructions)		55,649	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		3,196,541	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)		80,066	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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/24/2020 8:56 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		546,196		2,435,690	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/30/2020	98,400	01/30/2020	94,100	3.01
3.02		04/29/2020	37,300	04/29/2020	30,100	3.02
3.03			0	06/11/2020	636,651	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)		135,700		760,851	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)		681,896		3,196,541	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		80,066	6.01
6.02	SETTLEMENT TO PROGRAM		161,576		0	6.02
7.00	Total Medicare program liability (see instructions)		520,320		3,276,607	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: 14-1301

Period:

Worksheet E-1

Component CCN: 14-Z301

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/24/2020 8:56 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,854,767		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	06/11/2020	329,076		0	3.01
3.02		01/30/2020	90,300		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)		419,376		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)		2,274,143		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		154,302		0	6.02
7.00	Total Medicare program liability (see instructions)		2,119,841		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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/24/2020 8:56 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2	
		Component CCN: 14-Z301		Date/Time Prepared: 11/24/2020 8:56 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,788,252	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)		381,975	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		629	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)		2,170,227	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,170,227	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,170,227	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		14,383	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,155,844	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,155,844	0	19.00
19.01	Sequestration adjustment (see instructions)		36,003	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		2,274,143	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)		-154,302	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: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/24/2020 8:56 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		573,189	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		573,189	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		578,921	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		578,921	19.00
20.00	Deductibles (exclude professional component)		49,764	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		529,157	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		529,157	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		529,157	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		529,157	30.00
30.01	Sequestration adjustment (see instructions)		8,837	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		681,896	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-161,576	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1301

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

Worksheet G

Date/Time Prepared:
11/24/2020 8:56 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	12,817,706	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	4,516,423	0	0	0	4.00
5.00 Other receivable	220,344	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	0	0	0	0	7.00
8.00 Prepaid expenses	1,422,564	0	0	0	8.00
9.00 Other current assets	508,181	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)	19,485,218	0	0	0	11.00
FIXED ASSETS					
12.00 Land	7,636,110	0	0	0	12.00
13.00 Land improvements	24,038,210	0	0	0	13.00
14.00 Accumulated depreciation	-2,908,833	0	0	0	14.00
15.00 Buildings	0	0	0	0	15.00
16.00 Accumulated depreciation	0	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	30,494,721	0	0	0	19.00
20.00 Accumulated depreciation	-25,182,098	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	381,254	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	34,459,364	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	2,851,057	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	50,113,818	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	52,964,875	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	106,909,457	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	915,781	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,696,294	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,004,733	0	0	0	40.00
41.00 Deferred income	4,158,817	0	0	0	41.00
42.00 Accelerated payments	827,204	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,121,710	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	10,724,539	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	28,200,695	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	194,670	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	28,395,365	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	39,119,904	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	67,789,553				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)	67,789,553	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	106,909,457	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1301

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

Worksheet G-1

Date/Time Prepared:
11/24/2020 8:56 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		64,823,229		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,292,575				2.00
3.00	Total (sum of line 1 and line 2)		68,115,804		0		3.00
4.00	CHANGE IN INTEREST PERPETUAL TRUST	137,266		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)		137,266		0		10.00
11.00	Subtotal (line 3 plus line 10)		68,253,070		0		11.00
12.00	CAPITAL CONTRIBUTIONS	454,832		0		0	12.00
13.00	AUXILIARY LOSS	8,685		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)		463,517		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,789,553		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CHANGE IN INTEREST PERPETUAL TRUST		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	CAPITAL CONTRIBUTIONS		0				12.00
13.00	AUXILIARY LOSS		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: 14-1301

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2020 8:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,319,917		1,319,917	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	4,770,400		4,770,400	5.00
6.00	Swing bed - NF	333,750		333,750	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)	6,424,067		6,424,067	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)	6,424,067		6,424,067	17.00
18.00	Ancillary services	2,745,281	51,666,869	54,412,150	18.00
19.00	Outpatient services	0	11,471,254	11,471,254	19.00
20.00	RURAL HEALTH CLINIC	0	524,238	524,238	20.00
20.01	RURAL HEALTH CLINIC II	0	3,849,358	3,849,358	20.01
20.02	RURAL HEALTH CLINIC III	0	614,459	614,459	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,401,009	2,401,009	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	190,118	9,635,900	9,826,018	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,359,466	80,163,087	89,522,553	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,217,559		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		40,217,559		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1301

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

Worksheet G-3

Date/Time Prepared:
11/24/2020 8:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	89,522,553	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,550,406	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,972,147	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,217,559	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,245,412	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	27,390	6.00
7.00	Income from investments	878,244	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	173,284	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	44,839	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PHARMACY REVENUE	643,440	24.00
24.01	GRANT INCOME	353,271	24.01
24.02	FOUNDATION INCOME	114,642	24.02
24.03	RETAIL PHARMACY INCOME	70,368	24.03
24.04	TIF INCOME	51,318	24.04
24.05	AMBULANCE INCOME	57,201	24.05
24.06	MISCELLANEOUS INCOME	190,721	24.06
24.50	COVID-19 PHE Funding	2,935,248	24.50
25.00	Total other income (sum of lines 6-24)	5,539,966	25.00
26.00	Total (line 5 plus line 25)	3,294,554	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	1,979	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,979	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,292,575	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	72,728	0	72,728	0	72,728
2.00	Physician Assistant	106,092	0	106,092	-7,850	98,242
3.00	Nurse Practitioner	3,922	0	3,922	0	3,922
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	103,823	0	103,823	0	103,823
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	21,533	0	21,533	0	21,533
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)	308,098	0	308,098	-7,850	300,248
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	33,162	33,162	0	33,162
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	33,162	33,162	0	33,162
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	308,098	33,162	341,260	-7,850	333,410
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	7,850	7,850
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	7,850	7,850
FACILITY OVERHEAD						
29.00	Facility Costs	0	21,731	21,731	-3,367	18,364
30.00	Administrative Costs	59,665	148,291	207,956	-77,739	130,217
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,665	170,022	229,687	-81,106	148,581
32.00	Total facility costs (sum of lines 22, 28 and 31)	367,763	203,184	570,947	-81,106	489,841

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 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	72,728	1.00	
2.00	Physician Assistant	0	98,242	2.00	
3.00	Nurse Practitioner	0	3,922	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	103,823	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	21,533	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	300,248	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	33,162	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	33,162	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	333,410	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	7,850	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	7,850	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	18,364	29.00	
30.00	Administrative Costs	-15	130,202	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15	148,566	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15	489,826	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 am

		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	1,126,277	0	1,126,277	-51,360	1,074,917
2.00	Physician Assistant	126,797	0	126,797	-3,545	123,252
3.00	Nurse Practitioner	160,451	0	160,451	-1,903	158,548
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	674,001	0	674,001	-6,640	667,361
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	111,202	26,963	138,165	0	138,165
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)	2,198,728	26,963	2,225,691	-63,448	2,162,243
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	118,016	118,016	0	118,016
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	118,016	118,016	0	118,016
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,198,728	144,979	2,343,707	-63,448	2,280,259
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	56,808	56,808
25.02	Chronic Care Management	0	0	0	809	809
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	57,617	57,617
FACILITY OVERHEAD						
29.00	Facility Costs	0	3,772	3,772	0	3,772
30.00	Administrative Costs	651,411	989,139	1,640,550	-344,552	1,295,998
31.00	Total Facility Overhead (sum of lines 29 and 30)	651,411	992,911	1,644,322	-344,552	1,299,770
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,850,139	1,137,890	3,988,029	-350,383	3,637,646

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,074,917		1.00
2.00	Physician Assistant	0	123,252		2.00
3.00	Nurse Practitioner	0	158,548		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	667,361		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	138,165		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	2,162,243		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	118,016		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	118,016		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,280,259		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	56,808		25.01
25.02	Chronic Care Management	0	809		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	57,617		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	3,772		29.00
30.00	Administrative Costs	-292	1,295,706		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-292	1,299,478		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-292	3,637,354		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 am

		RHC III		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	54,106	0	54,106	0	54,106
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	199,441	0	199,441	-4,598	194,843
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	113,004	0	113,004	0	113,004
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	20,483	0	20,483	0	20,483
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)	387,034	0	387,034	-4,598	382,436
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	24,815	24,815	0	24,815
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	24,815	24,815	0	24,815
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	387,034	24,815	411,849	-4,598	407,251
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	4,598	4,598
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	4,598	4,598
FACILITY OVERHEAD						
29.00	Facility Costs	0	24,049	24,049	565	24,614
30.00	Administrative Costs	72,540	144,935	217,475	-90,655	126,820
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,540	168,984	241,524	-90,090	151,434
32.00	Total facility costs (sum of lines 22, 28 and 31)	459,574	193,799	653,373	-90,090	563,283

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 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	54,106	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	194,843	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	113,004	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	20,483	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	382,436	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	24,815	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	24,815	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	407,251	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	4,598	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	4,598	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	24,614	29.00
30.00	Administrative Costs	0	126,820	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	151,434	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	563,283	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1301 Component CCN: 14-3438		Period: From 07/01/2019 To 06/30/2020		Worksheet M-2 Date/Time Prepared: 11/24/2020 8:56 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	0.25	426	4,200	1,050			1.00
2.00	Physician Assistant	0.82	1,214	2,100	1,722			2.00
3.00	Nurse Practitioner	0.04	144	2,100	84			3.00
4.00	Subtotal (sum of lines 1 through 3)	1.11	1,784		2,856		2,856	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	0.28	310				310	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)	1.39	2,094				3,166	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)						333,410	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						7,850	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						341,260	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.976997	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						148,566	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						186,359	15.00
16.00	Total overhead (sum of lines 14 and 15)						334,925	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						334,925	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						327,221	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						660,631	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-3495

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 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	2.57	7,974	1	3
2.00	Physician Assistant	0.99	2,364	1	1
3.00	Nurse Practitioner	2.77	4,498	1	3
4.00	Subtotal (sum of lines 1 through 3)	6.33	14,836	7	14,836
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	1.30	1,582		1,582
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)	7.63	16,418		16,418
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)				2,280,259
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				57,617
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,337,876
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.975355
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,299,478
15.00	Parent provider overhead allocated to facility (see instructions)				2,646,691
16.00	Total overhead (sum of lines 14 and 15)				3,946,169
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				3,946,169
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				3,848,916
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				6,129,175

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-8566

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/24/2020 8:56 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	0.25	427	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.71	2,034	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.96	2,461		2	2,461	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	0.10	214			214	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)	2.06	2,675			2,675	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)					407,251	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					4,598	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					411,849	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.988836	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					151,434	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					329,710	15.00
16.00	Total overhead (sum of lines 14 and 15)					481,144	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					481,144	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					475,773	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					883,024	20.00

Health Financial Systems		KIRBY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-3438		Date/Time Prepared: 11/24/2020 8:56 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)			660,631	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			6,874	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			653,757	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,166	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)			3,166	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			206.49	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)		206.49	206.49	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	284	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	58,643	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	413	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	413	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	59,056	16.00
16.01	Total program charges (see instructions)(from contractor's records)			64,102	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			6,454	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			5,946	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.)			37,324	16.04
16.05	Total program cost (see instructions)		0	43,270	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,455	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			10,239	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			43,270	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			734	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			44,004	22.00
23.00	Allowable bad debts (see instructions)			5,010	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			3,257	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,774	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)			47,261	26.00
26.01	Sequestration adjustment (see instructions)			789	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			44,188	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)			2,284	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		KIRBY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-3495		Date/Time Prepared: 11/24/2020 8:56 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)			6,129,175	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			37,840	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,091,335	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,418	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)			16,418	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			371.02	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)		371.02	371.02	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,614	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	969,846	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	72	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	26,713	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	26,713	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	996,559	16.00
16.01	Total program charges (see instructions)(from contractor's records)			604,935	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			37,672	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			62,060	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.)			705,795	16.04
16.05	Total program cost (see instructions)		0	767,855	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			52,255	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			102,824	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			767,855	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,981	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			770,836	22.00
23.00	Allowable bad debts (see instructions)			26,081	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			16,953	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,958	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)			787,789	26.00
26.01	Sequestration adjustment (see instructions)			13,156	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			717,918	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)			56,715	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: 14-1301 Component CCN: 14-8566	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/24/2020 8:56 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)			883,024	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,695	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			875,329	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,675	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			2,675	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			327.23	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)			327.23	327.23	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	435	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	142,345	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	142,345	16.00
16.01	Total program charges (see instructions)(from contractor's records)				91,223	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				4,736	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				7,390	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.)				99,189	16.04
16.05	Total program cost (see instructions)			0	106,579	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				10,969	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				15,071	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				106,579	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				669	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				107,248	22.00
23.00	Allowable bad debts (see instructions)				2,379	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				1,546	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				930	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)				108,794	26.00
26.01	Sequestration adjustment (see instructions)				1,817	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				76,901	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)				30,076	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: 14-1301 Component CCN: 14-3438	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/24/2020 8:56 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)		300,248	300,248	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000077	0.003190	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		23	958	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		306	2,182	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		329	3,140	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		333,410	333,410	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		327,221	327,221	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000987	0.009418	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		323	3,082	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		652	6,222	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		3	125	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		217.33	49.78	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		435	299	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)			6,874	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)			734	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/24/2020 8:56 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)		2,162,243	2,162,243	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000140	0.001275	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		303	2,757	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,081	6,936	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,384	9,693	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,280,259	2,280,259	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,848,916	3,848,916	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001923	0.004251	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,401	16,362	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		11,785	26,055	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		40	365	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		294.63	71.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		6	17	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,768	1,213	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)			37,840	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)			2,981	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/24/2020 8:56 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)		382,436	382,436	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000078	0.002038	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		30	779	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		510	2,230	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		540	3,009	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		407,251	407,251	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		475,773	475,773	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001326	0.007389	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		631	3,515	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,171	6,524	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		5	130	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		234.20	50.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		468	201	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)			7,695	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)			669	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/24/2020 8:56 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		44,188	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)		44,188	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		2,284	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		46,472	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: 14-1301 Component CCN: 14-3495	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/24/2020 8:56 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		571,018	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		01/30/2020	36,300	3.01
3.02		06/11/2020	110,600	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)		146,900	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		717,918	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		56,715	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		774,633	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: 14-1301 Component CCN: 14-8566	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/24/2020 8:56 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		76,901	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)		76,901		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		30,076		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		106,977		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00