

State Copy

Health Financial Systems

WARNER HOSPITAL AND HEALTH SERVICES

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim 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:14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet 5
Parts I-III
Date/Time Prepared:
9/3/2020 9:32 am

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date: 9/3/2020 Time: 9:32 am
2. ☐ Manually prepared cost report
3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. ☐ Cost Report Status 6. Date Received: 10. NPR Date:
(1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. ☐ Initial Report for this Provider CCN 12. ☐ If line 5, column 1 is 4: Enter
(3) Settled with Audit 9. ☐ Final Report for this Provider CCN number of times reopened = 0-9.
(4) Reopened
(5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 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) Paul Showen
Officer or Administrator of Provider(s)

Title CEO

Date 9/21/20

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	210,978	225,065	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	3,262	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		150,599		0	10.00
200.00	Total	0	214,240	375,664	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: 14-1303		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/3/2020 9:32 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 422 WEST WHITE STREET			PO Box:				1.00	
2.00	City: CLINTON			State: IL		Zip Code: 61727		County: DEWITT 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		WARNER HOSPITAL AND HEALTH SERVICES	141303	99914	1	03/01/2000	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		SWING BED	14Z303	99914		03/01/2000	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		RURAL HEALTH CENTER	143404	99914		07/03/1995	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020	20.00
21.00	Type of Control (see instructions)						12		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/3/2020 9:32 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.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
				Beginning:	Ending:		
				1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
				Y/N	Y/N		
				1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
				V	XVIII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/3/2020 9:32 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	
		1.00	2.00	3.00	4.00
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
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)				0.00
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)				0.00
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)				0.00
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				0.00
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)				0.00
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)				0.00
		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
61.20	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
					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
62.01	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
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/3/2020 9:32 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			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)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
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			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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:	63,475		0		118.01	
				1.00			
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1303		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/3/2020 9:32 am	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
		1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y	Y	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							166.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/3/2020 9:32 am
			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.			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)			0.00169.00
			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)			0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1303		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part II Date/Time Prepared: 9/3/2020 9:32 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/27/2020	Y	05/27/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/3/2020 9:32 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/3/2020 9:32 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 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	15	5,490	6,899.85	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)		15	5,490	6,899.85	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)		15	5,490	6,899.85	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		15				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: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/3/2020 9:32 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)	132	0	219			1.00
2.00	HMO and other (see instructions)	12	3				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	4	0	4			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	136	0	223			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)	136	0	223	0.00	110.35	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	5,774	0	15,167	0.00	20.77	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	131.12	27.00
28.00	Observation Bed Days		0	320			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/3/2020 9:32 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	45	0	107	1.00
2.00 HMO and other (see instructions)			4	1		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	45	0	107	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1303 Component CCN: 14-3404		Period: From 05/01/2019 To 04/30/2020		Worksheet S-8 Date/Time Prepared: 9/3/2020 9:32 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			422 W WHITE STREET			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			CLINTON IL 61727			2.00		
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:30			17:00		07:30
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N			0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County			DEWITT					2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00			07:30		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-1303 Component CCN:14-3404		Period: From 05/01/2019 To 04/30/2020		Worksheet S-8 Date/Time Prepared: 9/3/2020 9:32 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:30	17:00	09:00	13:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet S-10

Date/Time Prepared:
9/3/2020 9:32 am

				9/3/2020 9:32 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)			0.548564	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,116,687	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			5,995,793	6.00
7.00	Medicaid cost (line 1 times line 6)			3,289,076	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)			1,172,389	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)			1,172,389	19.00
				Uninsured patients	Insured patients
				1.00	2.00
				Total (col. 1 + col. 2)	
				3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)			301,453	165,817
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			165,366	165,817
22.00	Payments received from patients for amounts previously written off as charity care			0	0
23.00	Cost of charity care (line 21 minus line 22)			165,366	165,817
				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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			846,772	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			239,919	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			369,106	
28.00	Non-Medicare bad debt expense (see instructions)			477,666	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			391,217	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			722,400	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,894,789	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		333,098	333,098	45,583	378,681	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		593,274	593,274	13,952	607,226	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,173,496	2,173,496	-173,342	2,000,154	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,114,014	1,505,558	2,619,572	4,440	2,624,012	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	227,245	656,467	883,712	0	883,712	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,696	39,696	0	39,696	8.00
9.00	00900	HOUSEKEEPING	139,891	28,398	168,289	0	168,289	9.00
10.00	01000	DIETARY	147,185	117,980	265,165	-88,326	176,839	10.00
11.00	01100	CAFETERIA	0	0	0	86,603	86,603	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	131,333	13,400	144,733	0	144,733	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,167	366,598	432,765	-359,352	73,413	14.00
15.00	01500	PHARMACY	169,809	880,571	1,050,380	-333,821	716,559	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	209,393	75,963	285,356	0	285,356	16.00
17.00	01700	SOCIAL SERVICE	0	1,786	1,786	0	1,786	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	186,050	186,050	0	186,050	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	736,108	178,312	914,420	-31,718	882,702	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	208,205	137,679	345,884	1,007	346,891	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,379	581,879	921,258	0	921,258	54.00
60.00	06000	LABORATORY	381,039	459,419	840,458	6,343	846,801	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,622	1,622	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	108,026	108,026	64.00
65.00	06500	RESPIRATORY THERAPY	174,338	43,544	217,882	-24,026	193,856	65.00
66.00	06600	PHYSICAL THERAPY	0	490,371	490,371	-16,251	474,120	66.00
69.00	06900	ELECTROCARDIOLOGY	118,540	1,487	120,027	0	120,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	376,984	376,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,856	78,856	0	78,856	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	333,821	333,821	73.00
76.00	03950	CARDIAC REHAB	65,562	5,619	71,181	600	71,781	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,685,707	255,144	1,940,851	82,019	2,022,870	88.00
90.00	09000	CLINIC	0	0	0	2,074	2,074	90.00
91.00	09100	EMERGENCY	997,140	1,439,400	2,436,540	-32,108	2,404,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		21,000	21,000	-21,000	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,911,055	10,665,045	17,576,100	-16,870	17,559,230	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	65,521	1,418	66,939	103	67,042	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	20,222	4,390	24,612	16,767	41,379	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,996,798	10,670,853	17,667,651	0	17,667,651	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-21,000	357,681	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	607,226	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	698,921	2,699,075	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-67,079	2,556,933	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	883,712	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,696	8.00
9.00	00900	HOUSEKEEPING	0	168,289	9.00
10.00	01000	DIETARY	-71,696	105,143	10.00
11.00	01100	CAFETERIA	-31,312	55,291	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	144,733	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	73,413	14.00
15.00	01500	PHARMACY	-228,103	488,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,947	280,409	16.00
17.00	01700	SOCIAL SERVICE	0	1,786	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	186,050	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-202,875	679,827	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-81,928	264,963	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	921,258	54.00
60.00	06000	LABORATORY	0	846,801	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,622	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	108,026	64.00
65.00	06500	RESPIRATORY THERAPY	-400	193,456	65.00
66.00	06600	PHYSICAL THERAPY	-23,100	451,020	66.00
69.00	06900	ELECTROCARDIOLOGY	-23,023	97,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	376,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,856	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,990	329,831	73.00
76.00	03950	CARDIAC REHAB	0	71,781	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-500	2,022,370	88.00
90.00	09000	CLINIC	0	2,074	90.00
91.00	09100	EMERGENCY	0	2,404,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-61,032	17,498,198	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	67,042	192.00
192.01	19201	LIFELINE	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	41,379	192.03
192.04	19204	RENTAL PROPERTIES	0	0	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-61,032	17,606,619	200.00

RECLASSIFICATIONS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/3/2020 9:32 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS FROM DIET					
1.00	CAFETERIA	11.00	48,071	38,532		1.00
2.00	EMERGENCY	91.00	397	319		2.00
3.00	OPERATING ROOM	50.00	559	448		3.00
	TOTALS		49,027	39,299		
	B - TO RECLASS DRUGS SOLD TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	333,821		1.00
	TOTALS		0	333,821		
	C - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,000		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	21,000		
	D - TO RECLASS SUPPLIES CHARGED TO PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	352,958		1.00
	TOTALS		0	352,958		
	F - TO RECLSS PROPERTY INS EXP					
1.00	OTHER CAP REL COSTS	3.00	0	38,638		1.00
	TOTALS		0	38,638		
	G - TO RECLASS RHC ADMIN EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,429		1.00
	TOTALS		0	30,429		
	H - TO RECLASS OXYGEN SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,026		1.00
	TOTALS		0	24,026		
	I - TO RECLASS NURSING COST					
1.00	INTRAVENOUS THERAPY	64.00	108,026	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	1,622	0		2.00
	CLINIC	90.00	2,074	0		3.00
4.00	EMERGENCY	91.00	4,593	0		4.00
	TOTALS		116,315	0		
	J - TO RECLASS GRANT EXPENSES					
1.00	RURAL HEALTH CLINIC	88.00	0	4,929		1.00
2.00	EMERGENCY	91.00	0	1,342		2.00
3.00	CARDIAC REHAB	76.00	0	600		3.00
	TOTALS		0	6,871		
	K - TO RECLASS RHC PHYSICIAN TIME					
1.00	ADULTS & PEDIATRICS	30.00	39,921	743		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	11,254	0		2.00
	TOTALS		51,175	743		
	L - TO RECLASS ATHLETIC TRAINER COM BEN					
1.00	COMMUNITY BENEFIT	192.03	0	16,251		1.00
	TOTALS		0	16,251		
	N - TO RECLASS RHC LAB TESTS					
1.00	LABORATORY	60.00	6,343	0		1.00
	TOTALS		6,343	0		
	O - TO RECLASS RESTRICTED DONATIONS					
1.00	COMMUNITY BENEFIT	192.03	0	516		1.00
	TOTALS		0	516		
	P - OP CLINIC MME DEPRECIATION					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	103		1.00
	TOTALS		0	103		
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	165,780		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,174		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,388		3.00
	TOTALS		0	173,342		
	R - CELLPHONE EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,394		1.00
	TOTALS		0	6,394		
500.00	Grand Total: Increases		222,860	1,044,391		500.00

RECLASSIFICATIONS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
9/3/2020 9:32 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS FROM DIET						
1.00	DIETARY	10.00	49,027	39,299	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		49,027	39,299			
	B - TO RECLASS DRUGS SOLD TO PATIENTS						
1.00	PHARMACY	15.00	0	333,821	0		1.00
	TOTALS		0	333,821			
	C - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	21,000	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	21,000			
	D - TO RECLASS SUPPLIES CHARGED TO PTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	352,958	0		1.00
	TOTALS		0	352,958			
	F - TO RECLSS PROPERTY INS EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38,638	12		1.00
	TOTALS		0	38,638			
	G - TO RECLASS RHC ADMIN EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	30,429	0		1.00
	TOTALS		0	30,429			
	H - TO RECLASS OXYGEN SUPPLIES						
1.00	RESPIRATORY THERAPY	65.00	0	24,026	0		1.00
	TOTALS		0	24,026			
	I - TO RECLASS NURSING COST						
1.00	ADULTS & PEDIATRICS	30.00	77,556	0	0		1.00
2.00	EMERGENCY	91.00	38,759	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		116,315	0			
	J - TO RECLASS GRANT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,871	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	6,871			
	K - TO RECLASS RHC PHYSICIAN TIME						
1.00	RURAL HEALTH CLINIC	88.00	51,175	743	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		51,175	743			
	L - TO RECLASS ATHLETIC TRAINER COM BEN						
1.00	PHYSICAL THERAPY	66.00	0	16,251	0		1.00
	TOTALS		0	16,251			
	N - TO RECLASS RHC LAB TESTS						
1.00	RURAL HEALTH CLINIC	88.00	6,343	0	0		1.00
	TOTALS		6,343	0			
	O - TO RECLASS RESTRICTED DONATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	516	0		1.00
	TOTALS		0	516			
	P - OP CLINIC MME DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	103	9		1.00
	TOTALS		0	103			
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	173,342	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	173,342			
	R - CELLPHONE EXPENSES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,394	0		1.00
	TOTALS		0	6,394			
500.00	Grand Total: Decreases		222,860	1,044,391			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/3/2020 9:32 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	461,499	51,605	0	51,605	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	11,649,565	335,578	0	335,578	14,985	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	203,883	0	0	0	0	5.00	
6.00	Movable Equipment	5,422,209	475,350	0	475,350	265,212	6.00	
7.00	HIT designated Assets	1,041,254	0	0	0	33,968	7.00	
8.00	Subtotal (sum of lines 1-7)	18,778,410	862,533	0	862,533	314,165	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	18,778,410	862,533	0	862,533	314,165	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	513,104	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	11,970,158	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	203,883	0				5.00	
6.00	Movable Equipment	5,632,347	0				6.00	
7.00	HIT designated Assets	1,007,286	0				7.00	
8.00	Subtotal (sum of lines 1-7)	19,326,778	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	19,326,778	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/3/2020 9:32 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	333,098	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	593,274	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	926,372	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	333,098				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	593,274				2.00
3.00	Total (sum of lines 1-2)	0	926,372				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/3/2020 9:32 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	11,970,159	0	11,970,159	0.636248	24,583	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,843,516	0	6,843,516	0.363752	14,055	2.00
3.00	Total (sum of lines 1-2)	18,813,675	0	18,813,675	1.000000	38,638	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	24,583	333,098	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,055	593,171	0	2.00
3.00	Total (sum of lines 1-2)	0	0	38,638	926,269	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	24,583	0	0	357,681	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,055	0	0	607,226	2.00
3.00	Total (sum of lines 1-2)	0	38,638	0	0	964,907	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/3/2020 9:32 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 #		
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-21,000	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-1,043	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-307,826			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	66,982			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,312	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	B	-3,990	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,947	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,097	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/3/2020 9:32 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 #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER INCOME	B	-6,310	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OUTSIDE DIETARY SERVICES	B	-70,599	DIETARY	10.00	0	34.00
35.00	RESTING METABOLIC INCOME	B	-400	RESPIRATORY THERAPY	65.00	0	35.00
36.00	FITNESS MGMT	B	-3,750	PHYSICAL THERAPY	66.00	0	36.00
37.00	NON-ALLOW AMORTIZATION	A	0	RURAL HEALTH CLINIC	88.00	0	37.00
38.00	EHR DEPRECIATION - CAPITAL LEAS	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
39.00	OTHER REVENUE - RHC	B	-500	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	PEACE MEAL STAFF TIME	A	-1,293	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	LOBBYING EXPENSE	A	-7,208	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING AND MARKETING	A	-94,929	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	NON-ALLOWABLE PT PURCHASED SERVICE	A	-19,350	PHYSICAL THERAPY	66.00	0	43.00
44.00	CLINICAL TRAINING CLASSES	B	0	NURSING ADMINISTRATION	13.00	0	44.00
45.00	PENSION DIFFERENTIAL	A	698,921	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00	340B PROGRAM EXPENSES	A	-228,103	PHARMACY	15.00	0	46.00
47.00	OTHER REVENUE - CARDIAC REHAB	B	0	CARDIAC REHAB	76.00	0	47.00
48.00	NON-ALLOWABLE CONTRIBUTIONS	A	-15,872	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	INTEREST FROM INSURANCE COMPANIES	B	-7,406	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-61,032				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/3/2020 9:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	66,982	0
2.00		0.00			0	0
3.00		0.00			0	0
4.00		0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			66,982	0	0

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B		0.00	CITY OF CLINTON	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/3/2020 9:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	66,982	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	66,982			5.00

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

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

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

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

6.00	CITY GOVERNMENT	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:
9/3/2020 9:32 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	60.00	LABORATORY	1,262	0	1,262	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	23,023	23,023	0	0	0	2.00
3.00	50.00	OPERATING ROOM	81,928	81,928	0	0	0	3.00
4.00	91.00	EMERGENCY	1,349,204	0	1,349,204	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	202,875	202,875	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,658,292	307,826	1,350,466		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	60.00	LABORATORY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	23,023		2.00
3.00	50.00	OPERATING ROOM	0	0	0	81,928		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	202,875		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	307,826		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1303		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/3/2020 9:32 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						238	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						5.55	7.00
8.00	Optional travel expense rate per mile						0.54	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	3,433.25	2,805.50	904.75	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	84.93	60.89	13.78	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)	42.47	42.47	30.45			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)						291,586	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						170,827	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						462,413	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						12,467	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)						474,880	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)						474,880	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						10,108	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						10,108	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)						1,321	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						11,429	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)						11,429	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: 14-1303		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/3/2020 9:32 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	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	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)	84.93	60.89	13.78	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)					474,880	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					11,429	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)					486,309	63.00
64.00	Total cost of outside supplier services (from your records)					283,197	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					10,108	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,321	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					11,429	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					1,321	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					1,321	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: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	357,681	357,681			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	607,226		607,226		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,699,075	0	0	2,699,075	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,556,933	57,333	101,509	506,102	3,221,877
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	883,712	53,335	94,432	103,238	1,134,717
8.00	00800	LAUNDRY & LINEN SERVICE	39,696	5,211	9,227	0	54,134
9.00	00900	HOUSEKEEPING	168,289	1,855	3,285	63,553	236,982
10.00	01000	DIETARY	105,143	12,870	22,787	44,593	185,393
11.00	01100	CAFETERIA	55,291	0	0	21,839	77,130
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	144,733	2,055	3,638	59,665	210,091
14.00	01400	CENTRAL SERVICES & SUPPLY	73,413	7,478	13,240	30,060	124,191
15.00	01500	PHARMACY	488,456	4,919	8,709	77,145	579,229
16.00	01600	MEDICAL RECORDS & LIBRARY	280,409	12,054	21,343	95,128	408,934
17.00	01700	SOCIAL SERVICE	1,786	0	0	0	1,786
19.00	01900	NONPHYSICIAN ANESTHETISTS	186,050	0	0	0	186,050
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	679,827	29,139	51,592	299,182	1,059,740
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	264,963	33,423	59,177	94,842	452,405
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,258	13,418	23,757	154,181	1,112,614
60.00	06000	LABORATORY	846,801	6,980	12,358	175,677	1,041,816
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,622	0	0	737	2,359
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	108,026	1,943	3,439	49,077	162,485
65.00	06500	RESPIRATORY THERAPY	193,456	3,070	5,435	79,202	281,163
66.00	06600	PHYSICAL THERAPY	451,020	14,831	26,259	0	492,110
69.00	06900	ELECTROCARDIOLOGY	97,004	1,600	2,833	53,853	155,290
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	376,984	0	0	0	376,984
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,856	0	0	0	78,856
73.00	07300	DRUGS CHARGED TO PATIENTS	329,831	0	0	0	329,831
76.00	03950	CARDIAC REHAB	71,781	3,356	5,942	29,785	110,864
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,022,370	60,092	106,394	283,659	2,472,515
90.00	09000	CLINIC	2,074	0	0	942	3,016
91.00	09100	EMERGENCY	2,404,432	18,000	31,870	437,662	2,891,964
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,498,198	342,962	607,226	2,660,122	17,444,526
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	67,042	14,719	0	29,766	111,527
192.01	19201	LIFELINE	0	0	0	0	0
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0
192.03	19203	COMMUNITY BENEFIT	41,379	0	0	9,187	50,566
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	17,606,619	357,681	607,226	2,699,075	17,606,619

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,221,877					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	254,153	0	1,388,870			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,125	0	29,302	95,561		8.00
9.00	00900	HOUSEKEEPING	53,079	0	10,433	0	300,494	9.00
10.00	01000	DIETARY	41,524	0	72,363	0	16,118	10.00
11.00	01100	CAFETERIA	17,276	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	47,056	0	11,553	0	2,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,816	0	42,046	0	9,365	14.00
15.00	01500	PHARMACY	129,735	0	27,657	0	6,160	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91,593	0	67,777	0	15,096	16.00
17.00	01700	SOCIAL SERVICE	400	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	41,671	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	237,360	0	163,841	95,561	36,493	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	101,329	0	187,927	0	41,857	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,202	0	75,444	0	16,804	54.00
60.00	06000	LABORATORY	233,345	0	39,245	0	8,741	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	528	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	36,393	0	10,923	0	2,433	64.00
65.00	06500	RESPIRATORY THERAPY	62,975	0	17,259	0	3,844	65.00
66.00	06600	PHYSICAL THERAPY	110,222	0	83,391	0	18,574	66.00
69.00	06900	ELECTROCARDIOLOGY	34,782	0	8,997	0	2,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,662	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,875	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	24,831	0	18,870	0	4,203	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	553,791	0	337,870	0	75,253	88.00
90.00	09000	CLINIC	676	0	0	0	0	90.00
91.00	09100	EMERGENCY	647,736	0	101,211	0	22,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,185,571	0	1,306,109	95,561	282,061	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	24,980	0	82,761	0	18,433	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	11,326	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,221,877	0	1,388,870	95,561	300,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	315,398					10.00
11.00	01100	CAFETERIA	0	94,406				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,314	0	273,587		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,166	0	0	204,584	14.00
15.00	01500	PHARMACY	0	2,992	0	0	7,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,689	0	0	37	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	249	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	315,398	12,306	0	74,568	4,401	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,678	0	23,490	7,969	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,980	0	0	11,073	54.00
60.00	06000	LABORATORY	0	6,825	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	29	0	184	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,903	0	12,225	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,072	0	0	706	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	781	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,089	0	0	432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	122,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	1,155	0	7,408	593	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	28,687	0	40,201	4,029	88.00
90.00	09000	CLINIC	0	37	0	235	0	90.00
91.00	09100	EMERGENCY	0	16,974	0	107,906	16,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,398	92,896	0	266,217	204,437	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,154	0	7,370	147	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	356	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	315,398	94,406	0	273,587	204,584	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	753,493					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	587,126				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,186			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	227,970		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	12,557	2,186	0	2,014,411	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,330	0	0	843,985	50.00
53.00	05300	ANESTHESIOLOGY	0	14,079	0	227,970	242,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,265	0	0	1,618,382	54.00
60.00	06000	LABORATORY	0	106,205	0	0	1,436,177	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	777	0	0	3,877	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	35,098	0	0	261,460	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,317	0	0	374,336	65.00
66.00	06600	PHYSICAL THERAPY	0	51,494	0	0	756,572	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,407	0	0	215,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,088	0	0	601,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,178	0	0	126,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677,644	30,128	0	0	1,111,478	73.00
76.00	03950	CARDIAC REHAB	0	2,648	0	0	170,572	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	75,849	58,642	0	0	3,646,837	88.00
90.00	09000	CLINIC	0	387	0	0	4,351	90.00
91.00	09100	EMERGENCY	0	65,526	0	0	3,870,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	753,493	587,126	2,186	227,970	17,297,999	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	246,372	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	62,248	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	753,493	587,126	2,186	227,970	17,606,619	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,014,411	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	843,985	50.00
53.00	05300	ANESTHESIOLOGY	0	242,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,618,382	54.00
60.00	06000	LABORATORY	0	1,436,177	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,877	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	261,460	64.00
65.00	06500	RESPIRATORY THERAPY	0	374,336	65.00
66.00	06600	PHYSICAL THERAPY	0	756,572	66.00
69.00	06900	ELECTROCARDIOLOGY	0	215,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	601,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	126,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,111,478	73.00
76.00	03950	CARDIAC REHAB	0	170,572	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	3,646,837	88.00
90.00	09000	CLINIC	0	4,351	90.00
91.00	09100	EMERGENCY	0	3,870,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,297,999	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	246,372	192.00
192.01	19201	LIFELINE	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	62,248	192.03
192.04	19204	RENTAL PROPERTIES	0	0	192.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,606,619	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	57,333	101,509	158,842	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	0	53,335	94,432	147,767	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,211	9,227	14,438	0 8.00
9.00	00900	HOUSEKEEPING	0	1,855	3,285	5,140	0 9.00
10.00	01000	DIETARY	0	12,870	22,787	35,657	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	2,055	3,638	5,693	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,478	13,240	20,718	0 14.00
15.00	01500	PHARMACY	0	4,919	8,709	13,628	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,054	21,343	33,397	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	29,139	51,592	80,731	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	33,423	59,177	92,600	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,418	23,757	37,175	0 54.00
60.00	06000	LABORATORY	0	6,980	12,358	19,338	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,943	3,439	5,382	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	3,070	5,435	8,505	0 65.00
66.00	06600	PHYSICAL THERAPY	0	14,831	26,259	41,090	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	2,833	4,433	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	3,356	5,942	9,298	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	60,092	106,394	166,486	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	18,000	31,870	49,870	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	342,962	607,226	950,188	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	14,719	0	14,719	0 192.00
192.01	19201	LIFELINE	0	0	0	0	0 192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0 192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0 192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0 192.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	357,681	607,226	964,907	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	158,842					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	12,530	0	160,297			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	598	0	3,382	18,418		8.00
9.00	00900	HOUSEKEEPING	2,617	0	1,204	0	8,961	9.00
10.00	01000	DIETARY	2,047	0	8,352	0	481	10.00
11.00	01100	CAFETERIA	852	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,320	0	1,333	0	77	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,371	0	4,853	0	279	14.00
15.00	01500	PHARMACY	6,396	0	3,192	0	184	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,515	0	7,823	0	450	16.00
17.00	01700	SOCIAL SERVICE	20	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,054	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,702	0	18,910	18,418	1,088	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,995	0	21,690	0	1,248	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,285	0	8,707	0	501	54.00
60.00	06000	LABORATORY	11,504	0	4,529	0	261	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	26	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,794	0	1,261	0	73	64.00
65.00	06500	RESPIRATORY THERAPY	3,105	0	1,992	0	115	65.00
66.00	06600	PHYSICAL THERAPY	5,434	0	9,625	0	554	66.00
69.00	06900	ELECTROCARDIOLOGY	1,715	0	1,038	0	60	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,163	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	871	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,642	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,224	0	2,178	0	125	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	27,302	0	38,995	0	2,243	88.00
90.00	09000	CLINIC	33	0	0	0	0	90.00
91.00	09100	EMERGENCY	31,938	0	11,681	0	672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,053	0	150,745	18,418	8,411	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,231	0	9,552	0	550	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	558	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	158,842	0	160,297	18,418	8,961	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	46,537					10.00
11.00	01100	CAFETERIA	0	852				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	21	0	9,444		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11	0	0	27,232	14.00
15.00	01500	PHARMACY	0	27	0	0	1,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33	0	0	5	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	33	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,537	111	0	2,574	586	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33	0	811	1,061	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54	0	0	1,474	54.00
60.00	06000	LABORATORY	0	62	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	6	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	17	0	422	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	28	0	0	94	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	104	66.00
69.00	06900	ELECTROCARDIOLOGY	0	19	0	0	58	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	16,280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	10	0	256	79	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	260	0	1,388	536	88.00
90.00	09000	CLINIC	0	0	0	8	0	90.00
91.00	09100	EMERGENCY	0	153	0	3,725	2,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,537	839	0	9,190	27,212	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	10	0	254	20	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	3	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,537	852	0	9,444	27,232	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	24,455					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,223				16.00
17.00	01700	SOCIAL SERVICE	0	0	20			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,087		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	989	20		181,666	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,994	0		124,432	50.00
53.00	05300	ANESTHESIOLOGY	0	1,109	0		1,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,591	0		71,787	54.00
60.00	06000	LABORATORY	0	8,362	0		44,056	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	61	0		93	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	2,763	0		11,712	64.00
65.00	06500	RESPIRATORY THERAPY	0	419	0		14,258	65.00
66.00	06600	PHYSICAL THERAPY	0	4,055	0		60,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0	898	0		8,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,424	0		21,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	172	0		4,681	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,993	2,372	0		28,007	73.00
76.00	03950	CARDIAC REHAB	0	208	0		13,378	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,462	4,617	0		244,289	88.00
90.00	09000	CLINIC	0	30	0		71	90.00
91.00	09100	EMERGENCY	0	5,159	0		105,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,455	46,223	20	0	935,923	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		26,336	192.00
192.01	19201	LIFELINE	0	0	0		0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0		0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0		561	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0		0	192.04
200.00		Cross Foot Adjustments				2,087	2,087	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,455	46,223	20	2,087	964,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	181,666	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	124,432	50.00
53.00	05300	ANESTHESIOLOGY	0	1,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,787	54.00
60.00	06000	LABORATORY	0	44,056	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	93	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	11,712	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,258	65.00
66.00	06600	PHYSICAL THERAPY	0	60,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,681	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,007	73.00
76.00	03950	CARDIAC REHAB	0	13,378	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	244,289	88.00
90.00	09000	CLINIC	0	71	90.00
91.00	09100	EMERGENCY	0	105,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	935,923	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	26,336	192.00
192.01	19201	LIFELINE	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	561	192.03
192.04	19204	RENTAL PROPERTIES	0	0	192.04
200.00		Cross Foot Adjustments	0	2,087	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	964,907	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,446					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		55,082				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,941,131			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,208	9,208	1,114,014	-3,221,877	14,384,742	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,566	8,566	227,245	0	1,134,717	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	837	837	0	0	54,134	8.00
9.00	00900	HOUSEKEEPING	298	298	139,891	0	236,982	9.00
10.00	01000	DIETARY	2,067	2,067	98,158	0	185,393	10.00
11.00	01100	CAFETERIA	0	0	48,071	0	77,130	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	330	330	131,333	0	210,091	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,201	1,201	66,167	0	124,191	14.00
15.00	01500	PHARMACY	790	790	169,809	0	579,229	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,936	1,936	209,393	0	408,934	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,786	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	186,050	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,680	4,680	658,552	0	1,059,740	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,368	5,368	208,764	0	452,405	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155	2,155	339,379	0	1,112,614	54.00
60.00	06000	LABORATORY	1,121	1,121	386,696	0	1,041,816	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1,622	0	2,359	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	312	312	108,026	0	162,485	64.00
65.00	06500	RESPIRATORY THERAPY	493	493	174,338	0	281,163	65.00
66.00	06600	PHYSICAL THERAPY	2,382	2,382	0	0	492,110	66.00
69.00	06900	ELECTROCARDIOLOGY	257	257	118,540	0	155,290	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	376,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	78,856	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	329,831	73.00
76.00	03950	CARDIAC REHAB	539	539	65,562	0	110,864	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,651	9,651	624,383	0	2,472,515	88.00
90.00	09000	CLINIC	0	0	2,074	0	3,016	90.00
91.00	09100	EMERGENCY	2,891	2,891	963,371	0	2,891,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,082	55,082	5,855,388	-3,221,877	14,222,649	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,364	0	65,521	0	111,527	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	20,222	0	50,566	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	357,681	607,226	2,699,075		3,221,877	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.226387	11.024037	0.454303		0.223979	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		158,842	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011042	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: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	39,672			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	837	543		8.00
9.00	00900	HOUSEKEEPING	0	298	0	38,537	9.00
10.00	01000	DIETARY	0	2,067	0	2,067	543 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	330	0	330	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,201	0	1,201	0 14.00
15.00	01500	PHARMACY	0	790	0	790	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,936	0	1,936	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,680	543	4,680	543 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,368	0	5,368	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,155	0	2,155	0 54.00
60.00	06000	LABORATORY	0	1,121	0	1,121	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	312	0	312	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	493	0	493	0 65.00
66.00	06600	PHYSICAL THERAPY	0	2,382	0	2,382	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	257	0	257	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	539	0	539	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,651	0	9,651	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	2,891	0	2,891	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,308	543	36,173	543 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,364	0	2,364	0 192.00
192.01	19201	LIFELINE	0	0	0	0	0 192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0 192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0 192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0 192.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,388,870	95,561	300,494	315,398 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	35.008822	175.987109	7.797545	580.843462 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	160,297	18,418	8,961	46,537 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.040558	33.918969	0.232530	85.703499 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: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	5,358,165					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	131,333	0	2,417,484			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,167	0	0	590,339		14.00
15.00	01500	PHARMACY	169,809	0	0	22,277	488,353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	209,393	0	0	107	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	719	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	698,473	0	658,906	12,700	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	208,764	0	207,564	22,995	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,379	0	0	31,952	0	54.00
60.00	06000	LABORATORY	387,382	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,622	0	1,622	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	108,026	0	108,026	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	174,338	0	0	2,038	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,253	0	66.00
69.00	06900	ELECTROCARDIOLOGY	118,540	0	0	1,248	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	352,958	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	78,856	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	439,194	73.00
76.00	03950	CARDIAC REHAB	65,562	0	65,458	1,710	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,628,189	0	355,225	11,625	49,159	88.00
90.00	09000	CLINIC	2,074	0	2,074	0	0	90.00
91.00	09100	EMERGENCY	963,371	0	953,486	48,477	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,272,422	0	2,352,361	589,915	488,353	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	65,521	0	65,123	424	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	20,222	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	94,406	0	273,587	204,584	753,493	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.017619	0.000000	0.113170	0.346553	1.542927	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	852	0	9,444	27,232	24,455	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000159	0.000000	0.003907	0.046129	0.050076	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: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,533,220			16.00
17.00	01700	SOCIAL SERVICE	0	543		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	674,399	543	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,360,462	0	0	50.00
53.00	05300	ANESTHESIOLOGY	756,158	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,908,923	0	0	54.00
60.00	06000	LABORATORY	5,704,097	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,747	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,885,060	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	285,584	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,765,691	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	612,636	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	971,461	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,618,138	0	0	73.00
76.00	03950	CARDIAC REHAB	142,213	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,149,557	0	0	88.00
90.00	09000	CLINIC	20,791	0	0	90.00
91.00	09100	EMERGENCY	3,519,301	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,533,220	543	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	192.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	587,126	2,186	227,970	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.018619	4.025783	2,279.700000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,223	20	2,087	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001466	0.036832	20.870000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/3/2020 9:32 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	2,014,411		2,014,411	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	843,985		843,985	0
53.00	05300	ANESTHESIOLOGY	242,049		242,049	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,618,382		1,618,382	0
60.00	06000	LABORATORY	1,436,177		1,436,177	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,877		3,877	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
64.00	06400	INTRAVENOUS THERAPY	261,460		261,460	0
65.00	06500	RESPIRATORY THERAPY	374,336	0	374,336	0
66.00	06600	PHYSICAL THERAPY	756,572	0	756,572	0
69.00	06900	ELECTROCARDIOLOGY	215,001		215,001	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,827		601,827	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,024		126,024	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111,478		1,111,478	0
76.00	03950	CARDIAC REHAB	170,572		170,572	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,646,837		3,646,837	0
90.00	09000	CLINIC	4,351		4,351	0
91.00	09100	EMERGENCY	3,870,660		3,870,660	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,187,130		1,187,130	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	18,485,129	0	18,485,129	0
201.00		Less Observation Beds	1,187,130		1,187,130	0
202.00		Total (see instructions)	17,297,999	0	17,297,999	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/3/2020 9:32 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	254,306		254,306		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	352,508	1,007,954	1,360,462	0.620366	0.000000
53.00	05300	ANESTHESIOLOGY	224,933	531,225	756,158	0.320104	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,725	7,703,198	7,908,923	0.204627	0.000000
60.00	06000	LABORATORY	195,992	5,508,105	5,704,097	0.251780	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,747	41,747	0.092869	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	161,460	1,723,600	1,885,060	0.138701	0.000000
65.00	06500	RESPIRATORY THERAPY	65,891	219,693	285,584	1.310774	0.000000
66.00	06600	PHYSICAL THERAPY	6,830	2,758,861	2,765,691	0.273556	0.000000
69.00	06900	ELECTROCARDIOLOGY	31,934	580,702	612,636	0.350944	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	629,787	341,674	971,461	0.619507	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,002	117,002	1.077110	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	202,281	1,415,857	1,618,138	0.686887	0.000000
76.00	03950	CARDIAC REHAB	0	142,213	142,213	1.199412	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,149,557	3,149,557		88.00
90.00	09000	CLINIC	0	20,791	20,791	0.209273	0.000000
91.00	09100	EMERGENCY	61,365	3,457,936	3,519,301	1.099838	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,907	370,186	420,093	2.825874	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,442,919	29,090,301	31,533,220		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,442,919	29,090,301	31,533,220		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,014,411		2,014,411	0	2,014,411	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	843,985		843,985	0	843,985	50.00	
53.00	05300	ANESTHESIOLOGY	242,049		242,049	0	242,049	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,618,382		1,618,382	0	1,618,382	54.00	
60.00	06000	LABORATORY	1,436,177		1,436,177	0	1,436,177	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,877		3,877	0	3,877	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	261,460		261,460	0	261,460	64.00	
65.00	06500	RESPIRATORY THERAPY	374,336	0	374,336	0	374,336	65.00	
66.00	06600	PHYSICAL THERAPY	756,572	0	756,572	0	756,572	66.00	
69.00	06900	ELECTROCARDIOLOGY	215,001		215,001	0	215,001	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,827		601,827	0	601,827	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,024		126,024	0	126,024	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111,478		1,111,478	0	1,111,478	73.00	
76.00	03950	CARDIAC REHAB	170,572		170,572	0	170,572	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	3,646,837		3,646,837	0	3,646,837	88.00	
90.00	09000	CLINIC	4,351		4,351	0	4,351	90.00	
91.00	09100	EMERGENCY	3,870,660		3,870,660	0	3,870,660	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,187,130		1,187,130		1,187,130	92.00	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	18,485,129	0	18,485,129	0	18,485,129	200.00	
201.00		Less Observation Beds	1,187,130		1,187,130		1,187,130	201.00	
202.00		Total (see instructions)	17,297,999	0	17,297,999	0	17,297,999	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/3/2020 9:32 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	254,306		254,306		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	352,508	1,007,954	1,360,462	0.620366	0.000000
53.00	05300	ANESTHESIOLOGY	224,933	531,225	756,158	0.320104	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,725	7,703,198	7,908,923	0.204627	0.000000
60.00	06000	LABORATORY	195,992	5,508,105	5,704,097	0.251780	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,747	41,747	0.092869	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	161,460	1,723,600	1,885,060	0.138701	0.000000
65.00	06500	RESPIRATORY THERAPY	65,891	219,693	285,584	1.310774	0.000000
66.00	06600	PHYSICAL THERAPY	6,830	2,758,861	2,765,691	0.273556	0.000000
69.00	06900	ELECTROCARDIOLOGY	31,934	580,702	612,636	0.350944	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	629,787	341,674	971,461	0.619507	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,002	117,002	1.077110	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	202,281	1,415,857	1,618,138	0.686887	0.000000
76.00	03950	CARDIAC REHAB	0	142,213	142,213	1.199412	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,149,557	3,149,557	1.157889	0.000000
90.00	09000	CLINIC	0	20,791	20,791	0.209273	0.000000
91.00	09100	EMERGENCY	61,365	3,457,936	3,519,301	1.099838	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,907	370,186	420,093	2.825874	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,442,919	29,090,301	31,533,220		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,442,919	29,090,301	31,533,220		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, 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	124,432	1,360,462	0.091463	18,446	1,687	50.00
53.00	05300	ANESTHESIOLOGY	1,109	756,158	0.001467	10,974	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,787	7,908,923	0.009077	70,411	639	54.00
60.00	06000	LABORATORY	44,056	5,704,097	0.007724	67,765	523	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	93	41,747	0.002228	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	11,712	1,885,060	0.006213	22,492	140	64.00
65.00	06500	RESPIRATORY THERAPY	14,258	285,584	0.049926	49,186	2,456	65.00
66.00	06600	PHYSICAL THERAPY	60,862	2,765,691	0.022006	6,008	132	66.00
69.00	06900	ELECTROCARDIOLOGY	8,221	612,636	0.013419	4,548	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,867	971,461	0.022509	63,492	1,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,681	117,002	0.040008	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,007	1,618,138	0.017308	63,752	1,103	73.00
76.00	03950	CARDIAC REHAB	13,378	142,213	0.094070	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	244,289	3,149,557	0.077563	0	0	88.00
90.00	09000	CLINIC	71	20,791	0.003415	0	0	90.00
91.00	09100	EMERGENCY	105,434	3,519,301	0.029959	76	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	107,059	420,093	0.254846	1,248	318	92.00
200.00		Total (lines 50 through 199)	861,316	31,278,914		378,398	8,506	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/3/2020 9:32 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
53.00	05300	ANESTHESIOLOGY	227,970	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	CARDIAC REHAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	227,970	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/3/2020 9:32 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	1,360,462	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	227,970	0	756,158	0.301485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,908,923	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,704,097	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	41,747	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,885,060	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	285,584	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,765,691	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	612,636	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	971,461	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	117,002	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,618,138	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	142,213	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,149,557	0.000000	88.00
90.00	09000	CLINIC	0	0	0	20,791	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,519,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	420,093	0.000000	92.00
200.00		Total (lines 50 through 199)	0	227,970	0	31,278,914		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/3/2020 9:32 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	18,446	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,974	3,308	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	70,411	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	67,765	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	22,492	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	49,186	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,008	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,548	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	63,492	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	63,752	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	76	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,248	0	0	0	92.00
200.00		Total (lines 50 through 199)		378,398	3,308	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/3/2020 9:32 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	0.620366	0	405,739	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.320104	0	224,191	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204627	0	3,041,749	0	0	54.00	
60.00	06000	LABORATORY	0.251780	0	2,046,738	2,648	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.092869	0	28,855	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0.138701	0	964,896	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1.310774	0	86,120	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.273556	0	816,312	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.350944	0	249,945	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.619507	0	130,464	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.077110	0	55,018	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686887	0	580,435	0	0	73.00	
76.00	03950	CARDIAC REHAB	1.199412	0	83,081	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0			0	88.00	
90.00	09000	CLINIC	0.209273	0	9,106	0	0	90.00	
91.00	09100	EMERGENCY	1.099838	0	910,491	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.825874	0	226,059	0	0	92.00	
200.00		Subtotal (see instructions)		0	9,859,199	2,648	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	9,859,199	2,648	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/3/2020 9:32 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	251,707	0		50.00
53.00	05300	ANESTHESIOLOGY	71,764	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,424	0		54.00
60.00	06000	LABORATORY	515,328	667		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,680	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	133,832	0		64.00
65.00	06500	RESPIRATORY THERAPY	112,884	0		65.00
66.00	06600	PHYSICAL THERAPY	223,307	0		66.00
69.00	06900	ELECTROCARDIOLOGY	87,717	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	80,823	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,260	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	398,693	0		73.00
76.00	03950	CARDIAC REHAB	99,648	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,906	0		90.00
91.00	09100	EMERGENCY	1,001,393	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	638,814	0		92.00
200.00		Subtotal (see instructions)	4,302,180	667		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,302,180	667		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303
Component CCN: 14-Z303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description			Title XVIII		Swing Beds - SNF		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	227,970	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	227,970	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:

Worksheet D

Component CCN: 14-Z303

From 05/01/2019

Part IV

To 04/30/2020

Date/Time Prepared:

9/3/2020 9:32 am

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	1,360,462	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	227,970	0	756,158	0.301485 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,908,923	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	5,704,097	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	41,747	0.000000 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,885,060	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	285,584	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,765,691	0.000000 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	612,636	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	971,461	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	117,002	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,618,138	0.000000 73.00
76.00	03950	CARDIAC REHAB	0	0	0	142,213	0.000000 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,149,557	0.000000 88.00
90.00	09000	CLINIC	0	0	0	20,791	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	3,519,301	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	420,093	0.000000 92.00
200.00		Total (lines 50 through 199)	0	227,970	0	31,278,914	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:

From 05/01/2019

To 04/30/2020

Worksheet D

Part IV

Date/Time Prepared:

9/3/2020 9:32 am

Cost Center Description			Title XVIII		Swing Beds - SNF		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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	234	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	182	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	274	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	772	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,566	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
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
200.00		Total (lines 50 through 199)		3,028	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:

Worksheet D

Component CCN: 14-Z303

From 05/01/2019

Part V

To 04/30/2020

Date/Time Prepared:

9/3/2020 9:32 am

			Title XVIII	Swing Beds - SNF		Cost		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.620366	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.320104	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204627	0	0	0	0	54.00
60.00	06000	LABORATORY	0.251780	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.092869	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.138701	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.310774	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.273556	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.350944	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.619507	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.077110	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686887	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1.199412	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.209273	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.099838	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.825874	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:

Worksheet D

Component CCN: 14-Z303

From 05/01/2019
To 04/30/2020Part V
Date/Time Prepared:
9/3/2020 9:32 am

			Title XVIII		Swing Beds - SNF		Cost		
	Cost Center Description		Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
			ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0					62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03950	CARDIAC REHAB	0	0					76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/3/2020 9:32 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)		543	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		539	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)		219	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		4	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		132	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)		4	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,014,411	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		14,839	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,999,572	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)		1,999,572	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)		3,709.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		489,691	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)		489,691	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:

9/3/2020 9:32 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					203,993	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					693,684	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)					14,839	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					14,839	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)					320	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,709.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,187,130	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/3/2020 9:32 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	181,666	2,014,411	0.090183	1,187,130	107,059
91.00	Nursing School cost	0	2,014,411	0.000000	1,187,130	0
92.00	Allied health cost	0	2,014,411	0.000000	1,187,130	0
93.00	All other Medical Education	0	2,014,411	0.000000	1,187,130	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/3/2020 9:32 am	
		Title XIX	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)			543	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			539	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)			219	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			4	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,014,411	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			14,839	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,999,572	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)			1,999,572	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)			3,709.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0	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)			0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					320	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,709.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,187,130	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/3/2020 9:32 am

		Title XIX		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	181,666	2,014,411	0.090183	1,187,130	107,059
91.00	Nursing School cost	0	2,014,411	0.000000	1,187,130	0
92.00	Allied health cost	0	2,014,411	0.000000	1,187,130	0
93.00	All other Medical Education	0	2,014,411	0.000000	1,187,130	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/3/2020 9:32 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		151,861		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.620366	18,446	11,443	50.00
53.00	05300 ANESTHESIOLOGY	0.320104	10,974	3,513	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204627	70,411	14,408	54.00
60.00	06000 LABORATORY	0.251780	67,765	17,062	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.092869	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.138701	22,492	3,120	64.00
65.00	06500 RESPIRATORY THERAPY	1.310774	49,186	64,472	65.00
66.00	06600 PHYSICAL THERAPY	0.273556	6,008	1,644	66.00
69.00	06900 ELECTROCARDIOLOGY	0.350944	4,548	1,596	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.619507	63,492	39,334	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.077110	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.686887	63,752	43,790	73.00
76.00	03950 CARDIAC REHAB	1.199412	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.209273	0	0	90.00
91.00	09100 EMERGENCY	1.099838	76	84	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.825874	1,248	3,527	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		378,398	203,993	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)		378,398		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1303 Component CCN: 14-Z303	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/3/2020 9:32 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	0.620366	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.320104	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204627	0	0	54.00
60.00	06000 LABORATORY	0.251780	234	59	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.092869	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.138701	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1.310774	182	239	65.00
66.00	06600 PHYSICAL THERAPY	0.273556	274	75	66.00
69.00	06900 ELECTROCARDIOLOGY	0.350944	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.619507	772	478	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.077110	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.686887	1,566	1,076	73.00
76.00	03950 CARDIAC REHAB	1.199412	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.209273	0	0	90.00
91.00	09100 EMERGENCY	1.099838	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.825874	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,028	1,927	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,028		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/3/2020 9:32 am
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,302,847	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		0	2.00
3.00	OPPI 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)		4,302,847	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)		4,345,875	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)		14,919	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,565,661	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)		2,765,295	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)		2,765,295	30.00
31.00	Primary payer payments		622	31.00
32.00	Subtotal (line 30 minus line 31)		2,764,673	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)		240,223	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		156,145	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		202,164	36.00
37.00	Subtotal (see instructions)		2,920,818	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)		2,920,818	40.00
40.01	Sequestration adjustment (see instructions)		58,416	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,637,337	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)		225,065	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: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/3/2020 9:32 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		441,015		2,570,996	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	10/30/2019	66,341	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		66,341	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)		441,015		2,637,337	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		210,978		225,065	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		651,993		2,862,402	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1303

Period:

Worksheet E-1

Component CCN: 14-Z303

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/3/2020 9:32 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		13,332		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,332		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		3,262		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		16,594		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
9/3/2020 9:32 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:14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet E-2
		Component CCN:14-Z303	Date/Time Prepared: 9/3/2020 9:32 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)		14,987	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
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)		1,946	0
3.01	Nursing and allied health payment-PARHM (see instructions)			0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		4	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		16,933	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		16,933	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		16,933	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (see instructions)		16,933	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0	0
16.99	Demonstration payment adjustment amount before sequestration		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		16,933	0
19.01	Sequestration adjustment (see instructions)		339	0
19.02	Demonstration payment adjustment amount after sequestration)		0	0
19.03	Sequestration adjustment-PARHM pass-throughs			0
20.00	Interim payments		13,332	0
20.01	Interim payments-PARHM			0
21.00	Tentative settlement (for contractor use only)		0	0
21.01	Tentative settlement-PARHM (for contractor use only)			0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		3,262	0
22.01	Balance due provider/program-PARHM (see instructions)			0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0
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.			
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			
203.00	Total (sum of lines 201 and 202)			
204.00	Medicare swing-bed SNF discharges (see instructions)			
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			
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			
210.00	Reserved for future use			
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part V Date/Time Prepared: 9/3/2020 9:32 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		693,684	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)		693,684	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		700,621	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)		700,621	19.00
20.00	Deductibles (exclude professional component)		45,364	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		655,257	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		655,257	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		15,449	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		10,042	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,185	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		665,299	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)		665,299	30.00
30.01	Sequestration adjustment (see instructions)		13,306	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		441,015	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)		210,978	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/3/2020 9:32 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet G

Date/Time Prepared:
9/3/2020 9:32 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	3,465,279	0	0	0	1.00
2.00 Temporary investments	8,176,878	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	2,939,012	0	0	0	4.00
5.00 Other receivable	166,260	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-1,511,784	0	0	0	6.00
7.00 Inventory	342,323	0	0	0	7.00
8.00 Prepaid expenses	271,616	0	0	0	8.00
9.00 Other current assets	197,450	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)	14,047,034	0	0	0	11.00
FIXED ASSETS					
12.00 Land	513,103	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	11,970,159	0	0	0	15.00
16.00 Accumulated depreciation	-8,897,603	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	203,883	0	0	0	19.00
20.00 Accumulated depreciation	-105,610	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	5,632,347	0	0	0	23.00
24.00 Accumulated depreciation	-4,206,030	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	1,007,286	0	0	0	27.00
28.00 Accumulated depreciation	-1,007,286	0	0	0	28.00
29.00 Minor equipment-nondepreciable	97,791	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	5,208,040	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	3,079,745	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	1,289,791	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	4,369,536	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	23,624,610	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	429,306	0	0	0	37.00
38.00 Salaries, wages, and fees payable	925,316	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	35,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	10,500	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	1,400,122	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	565,000	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	1,543,472	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	2,108,472	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	3,508,594	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	20,116,016	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	20,116,016	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	23,624,610	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-1

Date/Time Prepared:
9/3/2020 9:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,058,906		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,982,542				2.00
3.00	Total (sum of line 1 and line 2)		20,041,448		0		3.00
4.00	CAPITAL GRANTS AND GIFTS	73,844		0		0	4.00
5.00	UNREALIZED GAINS	724		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)		74,568		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,116,016		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,116,016		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	CAPITAL GRANTS AND GIFTS		0				4.00
5.00	UNREALIZED GAINS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/3/2020 9:32 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	284,500		284,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,528		3,528	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	288,028		288,028	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)	288,028		288,028	17.00
18.00	Ancillary services	2,185,966	25,909,668	28,095,634	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,149,557	3,149,557	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	31,516	216,190	247,706	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,505,510	29,275,415	31,780,925	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,667,651		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)		17,667,651		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-3

Date/Time Prepared:
9/3/2020 9:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,780,925	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,796,722	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,984,203	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,667,651	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,316,552	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	11,666	6.00
7.00	Income from investments	177,059	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	31,312	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	3,990	17.00
18.00	Revenue from sale of medical records and abstracts	4,947	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	1,097	21.00
22.00	Rental of hospital space	37,079	22.00
23.00	Governmental appropriations	14,236	23.00
24.00	OTHER DIETARY REVENUE	70,599	24.00
24.01	SALE: MINOR EQUIPMENT/SUPPLIES	0	24.01
24.02	FITNESS CENTER	3,750	24.02
24.03	PHARM 340B RETAIL/CONTRACT REV	943,422	24.03
24.04	MISC OTHER	7,610	24.04
24.05	CRNA PASS THROUGH AND OTHER	0	24.05
24.06	MEDICAID EHR	8,500	24.06
24.07	CARES ACT FUNDS	350,809	24.07
25.00	Total other income (sum of lines 6-24)	1,666,076	25.00
26.00	Total (line 5 plus line 25)	2,982,628	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	LOSS ON DISPOSAL OF ASSET	86	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	86	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,982,542	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303

Period:

Worksheet M-1

Component CCN: 14-3404

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/3/2020 9:32 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	660,761	0	660,761	56,266	717,027
2.00	Physician Assistant	0	0	0	57,596	57,596
3.00	Nurse Practitioner	351,785	0	351,785	0	351,785
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	222,429	0	222,429	-6,343	216,086
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	389,374	71,460	460,834	0	460,834
10.00	Subtotal (sum of lines 1 through 9)	1,624,349	71,460	1,695,809	107,519	1,803,328
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	68,175	68,175	0	68,175
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	68,175	68,175	0	68,175
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,624,349	139,635	1,763,984	107,519	1,871,503
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	15,601	0	15,601	0	15,601
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)	15,601	0	15,601	0	15,601
FACILITY OVERHEAD						
29.00	Facility Costs	0	13,479	13,479	0	13,479
30.00	Administrative Costs	45,757	102,030	147,787	-25,500	122,287
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,757	115,509	161,266	-25,500	135,766
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,685,707	255,144	1,940,851	82,019	2,022,870

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303

Period:

Worksheet M-1

Component CCN: 14-3404

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/3/2020 9:32 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	717,027	1.00
2.00	Physician Assistant	0	57,596	2.00
3.00	Nurse Practitioner	0	351,785	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	216,086	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	460,834	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,803,328	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	68,175	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	68,175	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,871,503	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	15,601	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	15,601	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	13,479	29.00
30.00	Administrative Costs	-500	121,787	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-500	135,266	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-500	2,022,370	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1303

Period:

Worksheet M-2

Component CCN: 14-3404

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/3/2020 9:32 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.50	9,185	4,200	6,300		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.16	5,547	2,100	4,536		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.66	14,732		10,836	14,732	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	0.20	435			435	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.86	15,167			15,167	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,871,503	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					15,601	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,887,104	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.991733	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					135,266	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,624,467	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,759,733	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,759,733	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,745,185	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,616,688	20.00

Health Financial Systems		WARNER HOSPITAL AND HEALTH SERVICES		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1303	Period: From 05/01/2019 To 04/30/2020	Worksheet M-3	
		Component CCN: 14-3404		Date/Time Prepared: 9/3/2020 9:32 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,616,688	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			83,716	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,532,972	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,167	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,167	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			232.94	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		232.94	232.94	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	5,682	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,323,565	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	92	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	21,430	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	21,430	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,344,995	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,048,672	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,859	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			6,231	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.)			989,088	16.04
16.05	Total program cost (see instructions)		0	995,319	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			102,404	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			188,173	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			995,319	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			44,343	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,039,662	22.00
23.00	Allowable bad debts (see instructions)			113,434	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			73,732	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			103,244	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)			1,113,394	26.00
26.01	Sequestration adjustment (see instructions)			22,268	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			940,527	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)			150,599	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: 14-1303 Component CCN: 14-3404	Period: From 05/01/2019 To 04/30/2020	Worksheet M-4 Date/Time Prepared: 9/3/2020 9:32 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)		1,803,328	1,803,328	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001170	0.004400	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,110	7,935	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		18,688	14,587	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,798	22,522	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,871,503	1,871,503	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,745,185	1,745,185	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.011113	0.012034	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		19,394	21,002	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		40,192	43,524	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		118	445	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		340.61	97.81	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		65	227	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		22,140	22,203	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)			83,716	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)			44,343	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2019 To 04/30/2020	Worksheet M-5 Date/Time Prepared: 9/3/2020 9:32 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		940,527	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)		940,527	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		150,599	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,091,126	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101	8.00