

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet S
Parts I-III
Date/Time Prepared:
7/28/2021 4:06 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 4:06 pm
	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 number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(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 COMMUNITY HOSPITAL OF STAUNTON (14-1306) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-329,091	-283,216	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	-553,864	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		183,243		0	10.00
200.00	Total	0	-882,955	-99,973	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: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 4:06 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 400 CALDWELL STREET			PO Box:					1.00	
2.00	City: STAUNTON			State: IL		Zip Code: 62088-1499		County: MACOUPIN		
		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		COMMUNITY HOSPITAL OF STAUNTON	141306	41180	1	08/01/2000	N	O	N
4.00	Subprovider - IPF									3.00
5.00	Subprovider - IRF									4.00
6.00	Subprovider - (Other)									5.00
7.00	Swing Beds - SNF		COMMUNITY HOSPITAL OF STAUNTON-SWB	14Z306	41180		08/01/2000	N	O	N
8.00	Swing Beds - NF									6.00
9.00	Hospital-Based SNF									7.00
10.00	Hospital-Based NF									8.00
11.00	Hospital-Based OLTC									9.00
12.00	Hospital-Based HHA									10.00
13.00	Separately Certified ASC									11.00
14.00	Hospital-Based Hospice									12.00
15.00	Hospital-Based Health Clinic - RHC		COMMUNITY CLINIC OF STAUNTON	148580	41180		10/20/2017	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									13.00
17.00	Hospital-Based (CMHC) I									14.00
18.00	Renal Dialysis									15.00
19.00	Other									16.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
				Urban/Rural S	Date of Geogr		
				1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
				Beginning:	Ending:		
				1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
				Y/N	Y/N		
				1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
				V	XVIII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 4:06 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

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Provider CCN: 14-1306

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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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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.	N		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	Y	Y	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N	110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.					N	111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
				1.00	2.00	3.00	
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			186,835	0	0	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			N			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
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: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 4:06 pm	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: ANDERSON HEALTH CARE	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 06101		141.00	
142.00	Street: 6800 STATE ROUTE 162	PO Box:				142.00	
143.00	City: MARYVILLE	State: IL		Zip Code: 62062		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	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 4:06 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 4:06 pm	
		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)	Y					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.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/17/2021	Y	03/17/2021		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)	N		N			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: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 4:06 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
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.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		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.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRIAN	ENGELKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL OF STAUNTON		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(618) 635-4242	BENGELKE@STAUNTONHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 4:06 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CFO	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	13,608.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	13,608.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	13,608.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	413	6	567		1.00
2.00	HMO and other (see instructions)	39	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	674	0	917		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	53		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,087	6	1,537		7.00
8.00	INTENSIVE CARE UNIT	0	0	0		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,087	6	1,537	0.00	97.33
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC	1,343	0	4,073	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	10.38
28.00	Observation Bed Days		4	371		0.00
29.00	Ambulance Trips	0				107.71
30.00	Employee discount days (see instruction)			0		28.00
31.00	Employee discount days - IRF			0		29.00
32.00	Labor & delivery days (see instructions)	0	0	0		30.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		31.00
33.00	LTCH non-covered days	0				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	151	1	337	1.00
2.00 HMO and other (see instructions)			16	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	151	1	337	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 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: 14-1306 Component CCN: 14-8580		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 7/28/2021 4:06 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				325 N CALDWELL		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				STAUNTON IL 62088		2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				07:30		16:30		07:30
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				Y				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				MACOUPIN				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				16:30		08:00		18:30
				08:00		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1306 Component CCN: 14-8580		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 7/28/2021 4:06 pm	
						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			08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/28/2021 4:06 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.466098 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,127,000		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	5,259,616		6.00
7.00	Medicaid cost (line 1 times line 6)	2,451,496		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)	324,496		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)	324,496		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	480,227	108,782	589,009 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	223,833	108,782	332,615 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	223,833	108,782	332,615 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	429,375		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	57,786		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	88,902		27.01
28.00	Non-Medicare bad debt expense (see instructions)	340,473		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	189,810		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	522,425		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	846,921		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,345,720	1,345,720	131,484	1,477,204	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	260,606	260,606	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	74,433	1,321,472	1,395,905	136,496	1,532,401	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	460,005	1,271,639	1,731,644	-309,476	1,422,168	5.01
5.02	00550	DATA PROCESSING	199,958	368,235	568,193	-77,697	490,496	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	411,435	138,561	549,996	0	549,996	5.03
7.00	00700	OPERATION OF PLANT	209,954	441,100	651,054	50,561	701,615	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,160	44,160	13,014	57,174	8.00
9.00	00900	HOUSEKEEPING	238,152	30,089	268,241	17,133	285,374	9.00
10.00	01000	DIETARY	134,387	68,746	203,133	-80,226	122,907	10.00
11.00	01100	CAFETERIA	0	0	0	80,226	80,226	11.00
13.00	01300	NURSING ADMINISTRATION	187,565	8,046	195,611	24,290	219,901	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	135,708	23,430	159,138	0	159,138	16.00
17.00	01700	SOCIAL SERVICE	141,437	233	141,670	0	141,670	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	36,000	36,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,109,374	243,468	1,352,842	-110,175	1,242,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,319	8,904	43,223	0	43,223	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	36,000	36,000	-36,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,393	409,453	817,846	4,375	822,221	54.00
60.00	06000	LABORATORY	490,134	379,672	869,806	20,249	890,055	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	110,175	110,175	64.00
65.00	06500	RESPIRATORY THERAPY	221,454	42,645	264,099	-4,929	259,170	65.00
66.00	06600	PHYSICAL THERAPY	51,327	593,570	644,897	17,731	662,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,450	136,450	0	136,450	67.00
68.00	06800	SPEECH PATHOLOGY	993	11,574	12,567	0	12,567	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,417	11,637	130,054	50,284	180,338	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,229	1,558,548	1,748,777	11,074	1,759,851	73.00
76.00	03050	CARDIAC REHAB	91,988	13,528	105,516	0	105,516	76.00
76.01	03030	BEHAVIORAL HEALTH	129,070	124,364	253,434	609	254,043	76.01
76.02	03040	WOUND CARE	0	2,405	2,405	-2,405	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	853,882	88,278	942,160	6,457	948,617	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	747,591	1,655,423	2,403,014	10,242	2,413,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		360,098	360,098	-360,098	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,640,205	10,737,448	17,377,653	0	17,377,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,658	1,776	29,434	0	29,434	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	6,667,863	10,739,224	17,407,087	0	17,407,087	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-354,076	1,123,128	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,022	254,584	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-189,792	1,342,609	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-341,072	1,081,096	5.01
5.02	00550	DATA PROCESSING	155,135	645,631	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	-88,135	461,861	5.03
7.00	00700	OPERATION OF PLANT	20,974	722,589	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,174	8.00
9.00	00900	HOUSEKEEPING	0	285,374	9.00
10.00	01000	DIETARY	-180	122,727	10.00
11.00	01100	CAFETERIA	-22,488	57,738	11.00
13.00	01300	NURSING ADMINISTRATION	23,013	242,914	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-84,844	74,294	16.00
17.00	01700	SOCIAL SERVICE	0	141,670	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	36,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-145,000	1,097,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	43,223	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-46	822,175	54.00
60.00	06000	LABORATORY	-28,986	861,069	60.00
64.00	06400	INTRAVENOUS THERAPY	0	110,175	64.00
65.00	06500	RESPIRATORY THERAPY	0	259,170	65.00
66.00	06600	PHYSICAL THERAPY	0	662,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,567	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-18	180,320	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-52,897	1,706,954	73.00
76.00	03050	CARDIAC REHAB	0	105,516	76.00
76.01	03030	BEHAVIORAL HEALTH	-15,600	238,443	76.01
76.02	03040	WOUND CARE	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	948,617	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-666,081	1,747,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,796,115	15,581,538	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,434	192.00
194.00	07950	MOB	0	0	194.00
194.01	07951	MOB	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,796,115	15,610,972	200.00

RECLASSIFICATIONS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/28/2021 4:06 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - DEPRECIATION EXPENSE					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	251,118		
	0		0	251,118		
C - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	354,076	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,022	2.00	
	0		0	360,098		
E - CAFETERIA EXPENSE						
1.00	CAFETERIA	11.00	53,075	27,151	1.00	
	0		53,075	27,151		
F - OXYGEN EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	17,218	1.00	
	0		0	17,218		
G - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	31,992	1.00	
	0		0	31,992		
J - CRNA						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	36,000	1.00	
	0		0	36,000		
L - OBSERVATION IV THERAPY						
1.00	INTRAVENOUS THERAPY	64.00	110,175	0	1.00	
	0		110,175	0		
Q - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	798	1.00	
	0		0	798		
R - BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	136,496	1.00	
	0		0	136,496		
T - TELEPHONE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	78,113	1.00	
	0		0	78,113		
U - COVID RECLASS						
1.00	DATA PROCESSING	5.02	0	416	1.00	
2.00	OPERATION OF PLANT	7.00	0	49,763	2.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	0	13,014	3.00	
4.00	HOUSEKEEPING	9.00	0	17,133	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	24,290	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,375	6.00	
7.00	LABORATORY	60.00	0	20,249	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	12,289	8.00	
9.00	PHYSICAL THERAPY	66.00	0	17,731	9.00	
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	30,661	10.00	
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,074	11.00	
12.00	BEHAVIORAL HEALTH	76.01	0	609	12.00	
13.00	RURAL HEALTH CLINIC	88.00	0	7,255	13.00	
14.00	EMERGENCY	91.00	0	10,242	14.00	
	TOTALS		0	219,101		
V - WOUND CARE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,405	1.00	
	TOTALS		0	2,405		
500.00	Grand Total: Increases		163,250	1,160,490	500.00	

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	251,118	9		1.00
	0		0	251,118			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	360,098	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	360,098			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	53,075	27,151	0		1.00
	0		53,075	27,151			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	17,218	0		1.00
	0		0	17,218			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	31,992	12		1.00
	0		0	31,992			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	36,000	0		1.00
	0		0	36,000			
	L - OBSERVATION IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	110,175	0	0		1.00
	0		110,175	0			
	Q - UTILITIES						
1.00	RURAL HEALTH CLINIC	88.00	0	798	0		1.00
	0		0	798			
	R - BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	136,496	0		1.00
	0		0	136,496			
	T - TELEPHONE						
1.00	DATA PROCESSING	5.02	0	78,113	0		1.00
	0		0	78,113			
	U - COVID RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	219,101	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
	TOTALS		0	219,101			
	V - WOUND CARE RECLASS						
1.00	WOUND CARE	76.02	0	2,405	0		1.00
	TOTALS		0	2,405			
500.00	Grand Total: Decreases		163,250	1,160,490			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	546,486	0	0	0	0	1.00
2.00	Land Improvements	2,298,714	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,456,820	608,510	0	608,510	0	3.00
4.00	Building Improvements	8,585,473	0	0	0	0	4.00
5.00	Fixed Equipment	176,073	277,997	0	277,997	0	5.00
6.00	Movable Equipment	3,258,865	0	0	0	759,767	6.00
7.00	HIT designated Assets	716,599	0	0	0	645,788	7.00
8.00	Subtotal (sum of lines 1-7)	24,039,030	886,507	0	886,507	1,405,555	8.00
9.00	Reconciling Items	2,998	615,410	0	615,410	0	9.00
10.00	Total (line 8 minus line 9)	24,036,032	271,097	0	271,097	1,405,555	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	546,486	0				1.00
2.00	Land Improvements	2,298,714	0				2.00
3.00	Buildings and Fixtures	9,065,330	0				3.00
4.00	Building Improvements	8,585,473	0				4.00
5.00	Fixed Equipment	454,070	0				5.00
6.00	Movable Equipment	2,499,098	0				6.00
7.00	HIT designated Assets	70,811	0				7.00
8.00	Subtotal (sum of lines 1-7)	23,519,982	0				8.00
9.00	Reconciling Items	618,408	0				9.00
10.00	Total (line 8 minus line 9)	22,901,574	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,345,720	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,345,720	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,345,720				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,345,720				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,950,073	0	20,950,073	0.891664	28,526	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,569,909	24,511	2,545,398	0.108336	3,466	2.00
3.00	Total (sum of lines 1-2)	23,519,982	24,511	23,495,471	1.000000	31,992	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	28,526	1,094,602	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,466	251,118	0	2.00
3.00	Total (sum of lines 1-2)	0	0	31,992	1,345,720	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	28,526	0	0	1,123,128	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,466	0	0	254,584	2.00
3.00	Total (sum of lines 1-2)	0	31,992	0	0	1,377,712	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-354,076	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-6,022	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	0	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-36,649	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,707	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-855,667			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	99,016			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-22,488	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-18	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-52,897	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,147	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
30.99	Hospice (non-distinct) (see instructions)	A-8-3		0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	9
33.00	IHA LOBBYING FEES	A	-7,484	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-3,733	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02	MEDICAID PROVIDER TAX	B	-365,646	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	MISCELLANEOUS OPERATING REVENUE	B	-22,814	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	X-RAY FILM COPYING	B	-46	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	INSERVICE EDUCATION	B	-80	NURSING ADMINISTRATION	13.00	0	33.05
33.06	DIABETIC CONSULTATION	B	-180	DIETARY	10.00	0	33.06
33.07	PUBLIC RELATIONS SALARIES	A	-8,240	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.07
33.08	PUBLIC RELATIONS OTHER	A	-16,658	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	DOMESTIC CLAIMS	A	-134,944	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	PUBLIC RELATIONS BENEFITS	A	-1,635	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,796,115				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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 4:06 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ANDERSON HO	78,888	78,888	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ANDERSON HO	108,873	162,086	2.00
3.00	5.01	OTHER ADMINISTRATIVE AND GEN	ANDERSON HO	120,152	0	3.00
4.00	5.02	DATA PROCESSING	ANDERSON HO	723,328	568,193	4.00
4.01	5.03	BILLING, COLLECTION, & ADMIT	ANDERSON HO	199,522	287,657	4.01
4.02	7.00	OPERATION OF PLANT	ANDERSON HO	22,681	0	4.02
4.03	13.00	NURSING ADMINISTRATION	ANDERSON HO	23,093	0	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	ANDERSON HO	78,441	159,138	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,354,978	1,255,962	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			Name	Percentage of Ownership	
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	SW IL HLTH FAC	100.00	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 4:06 pm

	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	0	11		1.00
2.00	-53,213	0		2.00
3.00	120,152	0		3.00
4.00	155,135	0		4.00
4.01	-88,135	0		4.01
4.02	22,681	0		4.02
4.03	23,093	0		4.03
4.04	-80,697	0		4.04
5.00	99,016			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	HOSPITAL		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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 4:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	177,917	145,000	32,917	0	0	1.00
2.00	60.00	LABORATORY	80,994	28,986	52,008	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	3,600	0	3,600	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	45,600	15,600	30,000	0	0	4.00
5.00	91.00	EMERGENCY	1,537,725	666,081	871,644	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			1,845,836	855,667	990,169		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	145,000		1.00
2.00	60.00	LABORATORY	0	0	0	28,986		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0		3.00
4.00	76.01	BEHAVIORAL HEALTH	0	0	0	15,600		4.00
5.00	91.00	EMERGENCY	0	0	0	666,081		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	855,667		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm		
				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)						366	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						5.40	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	1,578.00	1,856.00	4,959.50	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	117.01	86.67	65.01	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.34	43.34	32.51			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)						184,642	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						160,860	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						322,417	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						667,919	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						667,919	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)						667,919	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)						15,862	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)						15,862	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)						1,976	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						17,838	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)						17,838	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						1,976	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: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm		
				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)	86.67	65.01	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						667,919	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						17,838	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)						685,757	63.00
64.00	Total cost of outside supplier services (from your records)						577,953	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						15,862	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,976	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						17,838	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						1,976	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						1,976	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm	
				Occupational 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)					366	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					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,839.00	171.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.16	61.62	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.08	41.08	30.81			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)					151,092	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					10,537	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					161,629	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					161,629	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)					161,629	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)					15,035	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)					15,035	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)					1,976	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					17,011	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)					17,011	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					1,976	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.16	61.62	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						161,629	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						17,011	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)						178,640	63.00
64.00	Total cost of outside supplier services (from your records)						136,450	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						15,035	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,976	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						17,011	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						1,976	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						1,976	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					69	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					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	173.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.95	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.48	39.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					13,658	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					13,658	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					13,658	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)					13,658	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,724	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,724	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)					373	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,097	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)					3,097	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					373	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: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/28/2021 4:06 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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)	78.95	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)						13,658	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,097	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)						16,755	63.00
64.00	Total cost of outside supplier services (from your records)						10,823	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,724	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						373	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,097	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						373	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						373	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

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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	1,123,128	1,123,128			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	254,584		254,584		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,342,609	2,093	477	1,345,179	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,081,096	93,688	21,351	92,283	1,288,418
5.02	00550	DATA PROCESSING	645,631	0	0	40,846	686,477
5.03	00560	BILLING, COLLECTION, & ADMITTING	461,861	0	0	84,045	545,906
7.00	00700	OPERATION OF PLANT	722,589	393,559	89,686	42,888	1,248,722
8.00	00800	LAUNDRY & LINEN SERVICE	57,174	12,949	2,951	0	73,074
9.00	00900	HOUSEKEEPING	285,374	9,356	2,132	48,648	345,510
10.00	01000	DIETARY	122,727	28,865	6,578	16,610	174,780
11.00	01100	CAFETERIA	57,738	18,103	4,126	10,842	90,809
13.00	01300	NURSING ADMINISTRATION	242,914	4,374	997	38,314	286,599
16.00	01600	MEDICAL RECORDS & LIBRARY	74,294	16,963	3,866	27,721	122,844
17.00	01700	SOCIAL SERVICE	141,670	0	0	28,892	170,562
19.00	01900	NONPHYSICIAN ANESTHETISTS	36,000	0	0	0	36,000
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,097,667	95,578	21,781	204,111	1,419,137
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,223	32,536	7,415	7,010	90,184
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	640	146	0	786
54.00	05400	RADIOLOGY-DIAGNOSTIC	822,175	48,281	11,003	83,424	964,883
60.00	06000	LABORATORY	861,069	39,518	9,006	100,121	1,009,714
64.00	06400	INTRAVENOUS THERAPY	110,175	0	0	22,506	132,681
65.00	06500	RESPIRATORY THERAPY	259,170	12,964	2,954	45,237	320,325
66.00	06600	PHYSICAL THERAPY	662,628	59,277	13,509	10,485	745,899
67.00	06700	OCCUPATIONAL THERAPY	136,450	0	0	0	136,450
68.00	06800	SPEECH PATHOLOGY	12,567	4,014	915	203	17,699
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,320	26,460	6,030	24,189	236,999
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,954	16,338	3,723	38,859	1,765,874
76.00	03050	CARDIAC REHAB	105,516	16,401	3,738	18,791	144,446
76.01	03030	BEHAVIORAL HEALTH	238,443	15,464	3,524	26,366	283,797
76.02	03040	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	948,617	85,909	19,578	174,425	1,228,529
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,747,175	33,817	7,707	152,713	1,941,412
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,581,538	1,067,147	243,193	1,339,529	15,508,516
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,998	0	0	5,998
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,434	49,983	11,391	5,650	96,458
194.00	07950	MOB	0	0	0	0	0
194.01	07951	MOB	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	15,610,972	1,123,128	254,584	1,345,179	15,610,972

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	
			5.01	5A.01	5.02	5.03	7.00	
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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,288,418					5.01
5.02	00550	DATA PROCESSING	61,753	748,230	748,230			5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	49,108	595,014	29,955	624,969		5.03
7.00	00700	OPERATION OF PLANT	112,331	1,361,053	68,519	0	1,429,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,574	79,648	4,010	0	29,207	8.00
9.00	00900	HOUSEKEEPING	31,081	376,591	18,959	0	21,104	9.00
10.00	01000	DIETARY	15,723	190,503	9,590	0	65,109	10.00
11.00	01100	CAFETERIA	8,169	98,978	4,983	0	40,834	11.00
13.00	01300	NURSING ADMINISTRATION	25,782	312,381	15,726	0	9,865	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,051	133,895	6,741	0	38,262	16.00
17.00	01700	SOCIAL SERVICE	15,343	185,905	9,359	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,238	39,238	1,975	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	127,661	1,546,798	77,870	27,058	215,582	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,113	98,297	4,949	970	73,388	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	71	857	43	888	1,445	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,798	1,051,681	52,945	173,953	108,902	54.00
60.00	06000	LABORATORY	90,831	1,100,545	55,405	160,829	89,137	60.00
64.00	06400	INTRAVENOUS THERAPY	11,936	144,617	7,280	10,576	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,815	349,140	17,577	23,344	29,243	65.00
66.00	06600	PHYSICAL THERAPY	67,099	812,998	40,929	63,206	133,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,275	148,725	7,487	9,656	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,592	19,291	971	704	9,055	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,320	258,319	13,005	7,571	59,683	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,853	1,924,727	96,897	77,325	36,853	73.00
76.00	03050	CARDIAC REHAB	12,994	157,440	7,926	2,256	36,994	76.00
76.01	03030	BEHAVIORAL HEALTH	25,530	309,327	15,572	3,226	34,880	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	110,515	1,339,044	67,411	0	193,776	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	174,645	2,116,057	106,524	63,377	76,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,279,201	15,499,299	742,608	624,969	1,303,301	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	540	6,538	329	0	13,529	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,677	105,135	5,293	0	112,742	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	1,288,418	15,610,972	748,230	624,969	1,429,572	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
			8.00	9.00	10.00	11.00	13.00	
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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	112,865					8.00
9.00	00900	HOUSEKEEPING	0	416,654				9.00
10.00	01000	DIETARY	0	21,650	286,852			10.00
11.00	01100	CAFETERIA	0	13,578	0	158,373		11.00
13.00	01300	NURSING ADMINISTRATION	0	3,280	0	6,014	347,266	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,723	0	4,351	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,535	23,247	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	112,865	71,690	286,852	32,038	164,233	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	24,404	0	1,100	5,641	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	480	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,213	0	13,094	0	54.00
60.00	06000	LABORATORY	0	29,640	0	15,715	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,532	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,724	0	7,100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	44,461	0	1,646	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,011	0	32	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,846	0	3,797	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,255	0	6,099	31,267	73.00
76.00	03050	CARDIAC REHAB	0	12,301	0	2,949	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	11,598	0	4,138	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	64,436	0	27,377	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	25,364	0	23,969	122,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,865	416,654	286,852	157,486	347,266	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	887	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	112,865	416,654	286,852	158,373	347,266	202.00

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,972					16.00
17.00	01700	SOCIAL SERVICE	0	223,046				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	41,213			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,485	223,046	0	2,766,517	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	304	0	0	209,053	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	278	0	41,213	45,204	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,542	0	0	1,491,330	0	54.00
60.00	06000	LABORATORY	50,433	0	0	1,501,704	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,316	0	0	169,321	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,320	0	0	443,448	0	65.00
66.00	06600	PHYSICAL THERAPY	19,830	0	0	1,116,805	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,028	0	0	168,896	0	67.00
68.00	06800	SPEECH PATHOLOGY	221	0	0	33,285	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374	0	0	364,595	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,248	0	0	2,209,671	0	73.00
76.00	03050	CARDIAC REHAB	707	0	0	220,573	0	76.00
76.01	03030	BEHAVIORAL HEALTH	1,012	0	0	379,753	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,692,044	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,874	0	0	2,554,320	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	195,972	223,046	41,213	15,366,519	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	20,396	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	224,057	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	195,972	223,046	41,213	15,610,972	0	202.00

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Cost Center Description		Total	
		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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	5.03
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
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	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03050	CARDIAC REHAB	76.00
76.01	03030	BEHAVIORAL HEALTH	76.01
76.02	03040	WOUND CARE	76.02
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MOB	194.00
194.01	07951	MOB	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	2,093	477	2,570	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	93,688	21,351	115,039	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	160	5.03
7.00	00700	OPERATION OF PLANT	0	393,559	89,686	483,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,949	2,951	15,900	8.00
9.00	00900	HOUSEKEEPING	0	9,356	2,132	11,488	9.00
10.00	01000	DIETARY	0	28,865	6,578	35,443	10.00
11.00	01100	CAFETERIA	0	18,103	4,126	22,229	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,374	997	5,371	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,963	3,866	20,829	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	95,578	21,781	117,359	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	32,536	7,415	39,951	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	640	146	786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,396	48,281	11,003	112,680	54.00
60.00	06000	LABORATORY	6,243	39,518	9,006	54,767	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,964	2,954	15,918	65.00
66.00	06600	PHYSICAL THERAPY	0	59,277	13,509	72,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,014	915	4,929	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,460	6,030	32,490	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,199	16,338	3,723	90,260	73.00
76.00	03050	CARDIAC REHAB	0	16,401	3,738	20,139	76.00
76.01	03030	BEHAVIORAL HEALTH	0	15,464	3,524	18,988	76.01
76.02	03040	WOUND CARE	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	85,909	19,578	105,487	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	33,817	7,707	41,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,838	1,067,147	243,193	1,440,178	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,998	0	5,998	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,983	11,391	61,374	192.00
194.00	07950	MOB	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	129,838	1,123,128	254,584	1,507,550	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	115,215					5.01
5.02	00550	DATA PROCESSING	5,522	5,600				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	4,391	224	4,775			5.03
7.00	00700	OPERATION OF PLANT	10,045	513	0	493,885		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	588	30	0	10,090	26,608	8.00
9.00	00900	HOUSEKEEPING	2,779	142	0	7,291	0	9.00
10.00	01000	DIETARY	1,406	72	0	22,494	0	10.00
11.00	01100	CAFETERIA	730	37	0	14,107	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,305	118	0	3,408	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	988	50	0	13,219	0	16.00
17.00	01700	SOCIAL SERVICE	1,372	70	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	290	15	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,416	583	207	74,480	26,608	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	725	37	7	25,354	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6	0	7	499	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,762	396	1,323	37,623	0	54.00
60.00	06000	LABORATORY	8,122	415	1,231	30,795	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,067	55	81	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,577	132	179	10,103	0	65.00
66.00	06600	PHYSICAL THERAPY	6,000	307	484	46,192	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,098	56	74	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	142	7	5	3,128	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,906	97	58	20,619	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,205	726	592	12,732	0	73.00
76.00	03050	CARDIAC REHAB	1,162	59	17	12,780	0	76.00
76.01	03030	BEHAVIORAL HEALTH	2,283	117	25	12,050	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,882	505	0	66,945	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,622	795	485	26,352	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,391	5,558	4,775	450,261	26,608	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48	2	0	4,674	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	776	40	0	38,950	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	115,215	5,600	4,775	493,885	26,608	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	21,793					9.00
10.00	01000	DIETARY	1,132	60,579				10.00
11.00	01100	CAFETERIA	710	0	37,834			11.00
13.00	01300	NURSING ADMINISTRATION	172	0	1,437	12,884		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	665	0	1,039	0	36,843	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,083	862	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	3,751	60,579	7,653	6,094	1,595	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,276	0	263	209	57	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	25	0	0	0	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,894	0	3,128	0	10,257	54.00
60.00	06000	LABORATORY	1,550	0	3,754	0	9,481	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	844	0	623	64.00
65.00	06500	RESPIRATORY THERAPY	509	0	1,696	0	1,376	65.00
66.00	06600	PHYSICAL THERAPY	2,326	0	393	0	3,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	569	67.00
68.00	06800	SPEECH PATHOLOGY	157	0	8	0	42	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,038	0	907	0	446	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641	0	1,457	1,160	4,558	73.00
76.00	03050	CARDIAC REHAB	643	0	705	0	133	76.00
76.01	03030	BEHAVIORAL HEALTH	607	0	989	0	190	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,370	0	6,540	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,327	0	5,726	4,559	3,736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,793	60,579	37,622	12,884	36,843	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	212	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	21,793	60,579	37,834	12,884	36,843	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,442					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	305				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,442		314,160	0	314,160	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		67,892	0	67,892	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		1,375	0	1,375	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		175,222	0	175,222	54.00
60.00	06000	LABORATORY	0		110,306	0	110,306	60.00
64.00	06400	INTRAVENOUS THERAPY	0		2,713	0	2,713	64.00
65.00	06500	RESPIRATORY THERAPY	0		32,576	0	32,576	65.00
66.00	06600	PHYSICAL THERAPY	0		132,236	0	132,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		1,797	0	1,797	67.00
68.00	06800	SPEECH PATHOLOGY	0		8,418	0	8,418	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		57,607	0	57,607	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		126,405	0	126,405	73.00
76.00	03050	CARDIAC REHAB	0		35,674	0	35,674	76.00
76.01	03030	BEHAVIORAL HEALTH	0		35,299	0	35,299	76.01
76.02	03040	WOUND CARE	0		0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		193,062	0	193,062	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		100,418	0	100,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,442	0	1,395,160	0	1,395,160	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		10,722	0	10,722	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		101,363	0	101,363	192.00
194.00	07950	MOB	0		0	0	0	194.00
194.01	07951	MOB	0		0	0	0	194.01
200.00		Cross Foot Adjustments		305	305	0	305	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,442	305	1,507,550	0	1,507,550	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	OTHER ADMINISTRATIV E AND GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	71,904					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		71,520				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134	134	6,585,190			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5,998	5,998	451,765	-1,288,418	14,322,554	5.01
5.02	00550	DATA PROCESSING	0	0	199,958	0	686,477	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	411,435	0	545,906	5.03
7.00	00700	OPERATION OF PLANT	25,196	25,196	209,954	0	1,248,722	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	829	0	0	73,074	8.00
9.00	00900	HOUSEKEEPING	599	599	238,152	0	345,510	9.00
10.00	01000	DIETARY	1,848	1,848	81,312	0	174,780	10.00
11.00	01100	CAFETERIA	1,159	1,159	53,075	0	90,809	11.00
13.00	01300	NURSING ADMINISTRATION	280	280	187,565	0	286,599	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	1,086	135,708	0	122,844	16.00
17.00	01700	SOCIAL SERVICE	0	0	141,437	0	170,562	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	36,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,119	6,119	999,199	0	1,419,137	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,083	2,083	34,319	0	90,184	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	41	41	0	0	786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	3,091	408,393	0	964,883	54.00
60.00	06000	LABORATORY	2,530	2,530	490,134	0	1,009,714	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	110,175	0	132,681	64.00
65.00	06500	RESPIRATORY THERAPY	830	830	221,454	0	320,325	65.00
66.00	06600	PHYSICAL THERAPY	3,795	3,795	51,327	0	745,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	136,450	67.00
68.00	06800	SPEECH PATHOLOGY	257	257	993	0	17,699	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	1,694	118,417	0	236,999	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046	1,046	190,229	0	1,765,874	73.00
76.00	03050	CARDIAC REHAB	1,050	1,050	91,988	0	144,446	76.00
76.01	03030	BEHAVIORAL HEALTH	990	990	129,070	0	283,797	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,500	5,500	853,882	0	1,228,529	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,165	2,165	747,591	0	1,941,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,320	68,320	6,557,532	-1,288,418	14,220,098	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	384	0	0	0	5,998	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,200	3,200	27,658	0	96,458	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,123,128	254,584	1,345,179		1,288,418	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.619826	3.559620	0.204273		0.089957	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,570		115,215	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000390		0.008044	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5A.02	5.02	5.03	7.00	8.00	
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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING	-748,230	14,862,742				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	595,014	32,317,580			5.03
7.00	00700	OPERATION OF PLANT	0	1,361,053	0	40,576		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,648	0	829	1,537	8.00
9.00	00900	HOUSEKEEPING	0	376,591	0	599	0	9.00
10.00	01000	DIETARY	0	190,503	0	1,848	0	10.00
11.00	01100	CAFETERIA	0	98,978	0	1,159	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	312,381	0	280	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	133,895	0	1,086	0	16.00
17.00	01700	SOCIAL SERVICE	0	185,905	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	39,238	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,546,798	1,399,233	6,119	1,537	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	98,297	50,145	2,083	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	857	45,906	41	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,051,681	8,994,805	3,091	0	54.00
60.00	06000	LABORATORY	0	1,100,545	8,316,716	2,530	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	144,617	546,898	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	349,140	1,207,157	830	0	65.00
66.00	06600	PHYSICAL THERAPY	0	812,998	3,270,047	3,795	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	148,725	499,317	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,291	36,405	257	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	258,319	391,520	1,694	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,924,727	3,998,599	1,046	0	73.00
76.00	03050	CARDIAC REHAB	0	157,440	116,665	1,050	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	309,327	166,835	990	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,339,044	0	5,500	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,116,057	3,277,332	2,165	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-748,230	14,751,069	32,317,580	36,992	1,537	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,538	0	384	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	105,135	0	3,200	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)		748,230	624,969	1,429,572	112,865	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.050343	0.019338	35.231960	73.432010	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		5,600	4,775	493,885	26,608	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000377	0.000148	12.171850	17.311646	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATIO N (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	35,564					9.00
10.00	01000	DIETARY	1,848	1,537				10.00
11.00	01100	CAFETERIA	1,159	0	4,939,539			11.00
13.00	01300	NURSING ADMINISTRATION	280	0	187,565	2,112,775		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	0	135,708	0	32,317,580	16.00
17.00	01700	SOCIAL SERVICE	0	0	141,437	141,437	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	6,119	1,537	999,199	999,199	1,399,233	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,083	0	34,319	34,319	50,145	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	41	0	0	0	45,906	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,091	0	408,393	0	8,994,805	54.00
60.00	06000	LABORATORY	2,530	0	490,134	0	8,316,716	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	110,175	0	546,898	64.00
65.00	06500	RESPIRATORY THERAPY	830	0	221,454	0	1,207,157	65.00
66.00	06600	PHYSICAL THERAPY	3,795	0	51,327	0	3,270,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	499,317	67.00
68.00	06800	SPEECH PATHOLOGY	257	0	993	0	36,405	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694	0	118,417	0	391,520	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,046	0	190,229	190,229	3,998,599	73.00
76.00	03050	CARDIAC REHAB	1,050	0	91,988	0	116,665	76.00
76.01	03030	BEHAVIORAL HEALTH	990	0	129,070	0	166,835	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,500	0	853,882	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,165	0	747,591	747,591	3,277,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,564	1,537	4,911,881	2,112,775	32,317,580	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	27,658	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	416,654	286,852	158,373	347,266	195,972	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.715611	186.631100	0.032062	0.164365	0.006064	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,793	60,579	37,834	12,884	36,843	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.612783	39.413793	0.007659	0.006098	0.001140	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		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
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	1,537	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0 100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,537 0	30.00
31.00	03100	INTENSIVE CARE UNIT	0 0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 0	50.00
51.00	05100	RECOVERY ROOM	0 0	51.00
53.00	05300	ANESTHESIOLOGY	0 100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
64.00	06400	INTRAVENOUS THERAPY	0 0	64.00
65.00	06500	RESPIRATORY THERAPY	0 0	65.00
66.00	06600	PHYSICAL THERAPY	0 0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
68.00	06800	SPEECH PATHOLOGY	0 0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
76.00	03050	CARDIAC REHAB	0 0	76.00
76.01	03030	BEHAVIORAL HEALTH	0 0	76.01
76.02	03040	WOUND CARE	0 0	76.02
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)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,537 100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	MOB	0 0	194.00
194.01	07951	MOB	0 0	194.01
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)	223,046 41,213	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	145.117762 412.130000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,442 305	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.239427 3.050000	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,766,517		2,766,517	0
31.00	03100	INTENSIVE CARE UNIT	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	209,053		209,053	0
51.00	05100	RECOVERY ROOM	0		0	0
53.00	05300	ANESTHESIOLOGY	45,204		45,204	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,491,330		1,491,330	0
60.00	06000	LABORATORY	1,501,704		1,501,704	0
64.00	06400	INTRAVENOUS THERAPY	169,321		169,321	0
65.00	06500	RESPIRATORY THERAPY	443,448	0	443,448	0
66.00	06600	PHYSICAL THERAPY	1,116,805	0	1,116,805	0
67.00	06700	OCCUPATIONAL THERAPY	168,896	0	168,896	0
68.00	06800	SPEECH PATHOLOGY	33,285	0	33,285	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	364,595		364,595	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,209,671		2,209,671	0
76.00	03050	CARDIAC REHAB	220,573		220,573	0
76.01	03030	BEHAVIORAL HEALTH	379,753		379,753	0
76.02	03040	WOUND CARE	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,692,044		1,692,044	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	2,554,320		2,554,320	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	551,410		551,410	0
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	15,917,929	0	15,917,929	0
201.00		Less Observation Beds	551,410		551,410	0
202.00		Total (see instructions)	15,366,519	0	15,366,519	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

			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	939,199		939,199			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	50,145	50,145	4.168970	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	45,906	45,906	0.984708	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	918,568	8,076,237	8,994,805	0.165799	0.000000	54.00
60.00	06000	LABORATORY	1,140,746	7,175,970	8,316,716	0.180565	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	73,626	473,272	546,898	0.309603	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	236,620	970,537	1,207,157	0.367349	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	371,810	2,898,237	3,270,047	0.341526	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,850	249,467	499,317	0.338254	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,761	26,644	36,405	0.914297	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,401	220,119	391,520	0.931230	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	624,054	3,374,545	3,998,599	0.552611	0.000000	73.00
76.00	03050	CARDIAC REHAB	4,569	112,096	116,665	1.890653	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0	166,835	166,835	2.276219	0.000000	76.01
76.02	03040	WOUND CARE	0	0	0	0.000000	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	650,874	650,874			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	284,165	2,993,167	3,277,332	0.779390	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,761	368,273	460,034	1.198629	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,116,130	27,852,324	32,968,454			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,116,130	27,852,324	32,968,454			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
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
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03050	CARDIAC REHAB	0.000000			76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000			76.01
76.02	03040	WOUND CARE	0.000000			76.02
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						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 4:06 pm

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	67,892	50,145	1.353914	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,375	45,906	0.029953	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,222	8,994,805	0.019480	227,278	4,427	54.00
60.00	06000	LABORATORY	110,306	8,316,716	0.013263	320,626	4,252	60.00
64.00	06400	INTRAVENOUS THERAPY	2,713	546,898	0.004961	7,805	39	64.00
65.00	06500	RESPIRATORY THERAPY	32,576	1,207,157	0.026986	93,992	2,536	65.00
66.00	06600	PHYSICAL THERAPY	132,236	3,270,047	0.040439	42,552	1,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,797	499,317	0.003599	28,678	103	67.00
68.00	06800	SPEECH PATHOLOGY	8,418	36,405	0.231232	2,051	474	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,607	391,520	0.147137	63,064	9,279	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,405	3,998,599	0.031612	221,933	7,016	73.00
76.00	03050	CARDIAC REHAB	35,674	116,665	0.305782	1,371	419	76.00
76.01	03030	BEHAVIORAL HEALTH	35,299	166,835	0.211580	0	0	76.01
76.02	03040	WOUND CARE	0	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	193,062	650,874	0.296620	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	100,418	3,277,332	0.030640	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,617	460,034	0.136114	0	0	92.00
200.00		Total (lines 50 through 199)	1,143,617	32,029,255		1,009,350	30,266	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 4:06 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	41,213	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03050	CARDIAC REHAB	0	0	0	0	0
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0
76.02	03040	WOUND CARE	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)	41,213	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 4:06 pm	
				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	50,145	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	41,213	0	45,906	0.897769	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	8,994,805	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	8,316,716	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	546,898	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,207,157	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	3,270,047	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	499,317	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	36,405	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	391,520	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	3,998,599	0.000000	73.00
76.00	03050	CARDIAC REHAB		0	0	0	116,665	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH		0	0	0	166,835	0.000000	76.01
76.02	03040	WOUND CARE		0	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	650,874	0.000000	88.00
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	3,277,332	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	460,034	0.000000	92.00
200.00		Total (lines 50 through 199)		0	41,213	0	32,029,255		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 4:06 pm

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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	227,278	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	320,626	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	7,805	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	93,992	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,552	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,678	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,051	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	63,064	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	221,933	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0.000000	1,371	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	0	0	76.02
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)		1,009,350	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 4:06 pm

				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	4.168970	0	16,747	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.984708	0	10,853	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165799	0	2,877,097	0	0	54.00	
60.00	06000	LABORATORY	0.180565	0	2,639,351	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.309603	0	422,427	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.367349	0	446,161	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.341526	0	1,117,605	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.338254	0	74,420	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.914297	0	8,365	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.931230	0	48,465	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.552611	0	2,394,618	0	0	73.00	
76.00	03050	CARDIAC REHAB	1.890653	0	65,402	0	0	76.00	
76.01	03030	BEHAVIORAL HEALTH	2.276219	0	138,260	0	0	76.01	
76.02	03040	WOUND CARE	0.000000	0	0	0	0	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.779390	0	765,703	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.198629	0	216,476	0	0	92.00	
200.00		Subtotal (see instructions)		0	11,241,950	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	11,241,950	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 4:06 pm

				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	69,818	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	10,687	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	477,020	0		54.00
60.00	06000	LABORATORY	476,574	0		60.00
64.00	06400	INTRAVENOUS THERAPY	130,785	0		64.00
65.00	06500	RESPIRATORY THERAPY	163,897	0		65.00
66.00	06600	PHYSICAL THERAPY	381,691	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,173	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,648	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,132	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,292	0		73.00
76.00	03050	CARDIAC REHAB	123,652	0		76.00
76.01	03030	BEHAVIORAL HEALTH	314,710	0		76.01
76.02	03040	WOUND CARE	0	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	596,781	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,474	0		92.00
200.00		Subtotal (see instructions)	4,406,334	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,406,334	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 4:06 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,908	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		938	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)		567	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		917	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		53	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)		413	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)		674	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		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,766,517	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)		9,465	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)		1,372,384	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,394,133	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)		1,394,133	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,486.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		613,834	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)		613,834	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					342,590	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					956,424	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,001,753	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)					1,001,753	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)					371	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,486.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					551,410	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1306		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 4:06 pm	
				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	314,160	2,766,517	0.113558	551,410	62,617		90.00	
91.00	Nursing School cost	0	2,766,517	0.000000	551,410	0		91.00	
92.00	Allied health cost	0	2,766,517	0.000000	551,410	0		92.00	
93.00	All other Medical Education	0	2,766,517	0.000000	551,410	0		93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 4:06 pm	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		355,252		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4.168970	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.984708	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165799	227,278	37,682	54.00
60.00	06000	LABORATORY	0.180565	320,626	57,894	60.00
64.00	06400	INTRAVENOUS THERAPY	0.309603	7,805	2,416	64.00
65.00	06500	RESPIRATORY THERAPY	0.367349	93,992	34,528	65.00
66.00	06600	PHYSICAL THERAPY	0.341526	42,552	14,533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.338254	28,678	9,700	67.00
68.00	06800	SPEECH PATHOLOGY	0.914297	2,051	1,875	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.931230	63,064	58,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.552611	221,933	122,643	73.00
76.00	03050	CARDIAC REHAB	1.890653	1,371	2,592	76.00
76.01	03030	BEHAVIORAL HEALTH	2.276219	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.779390	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.198629	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,009,350	342,590	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,009,350		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1306 Component CCN: 14-Z306	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 4:06 pm	
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4.168970	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.984708	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165799	72,600	12,037	54.00
60.00	06000	LABORATORY	0.180565	154,315	27,864	60.00
64.00	06400	INTRAVENOUS THERAPY	0.309603	2,363	732	64.00
65.00	06500	RESPIRATORY THERAPY	0.367349	28,828	10,590	65.00
66.00	06600	PHYSICAL THERAPY	0.341526	218,760	74,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.338254	147,727	49,969	67.00
68.00	06800	SPEECH PATHOLOGY	0.914297	3,603	3,294	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.931230	42,680	39,745	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.552611	160,851	88,888	73.00
76.00	03050	CARDIAC REHAB	1.890653	561	1,061	76.00
76.01	03030	BEHAVIORAL HEALTH	2.276219	0	0	76.01
76.02	03040	WOUND CARE	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.779390	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.198629	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		832,288	308,892	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)		832,288		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 4:06 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,406,334	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)		4,406,334	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 charge basis 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)		4,450,397	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)		45,947	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,699,628	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)		2,704,822	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)		2,704,822	30.00
31.00	Primary payer payments		546	31.00
32.00	Subtotal (line 30 minus line 31)		2,704,276	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)		75,417	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		49,021	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,367	36.00
37.00	Subtotal (see instructions)		2,753,297	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)		2,753,297	40.00
40.01	Sequestration adjustment (see instructions)		18,172	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,018,341	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)		-283,216	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: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 4:06 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,239,250		3,128,492	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	12/07/2020	74,453	12/07/2020	110,151	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)		-74,453		-110,151	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)		1,164,797		3,018,341	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		329,091		283,216	6.02
7.00	Total Medicare program liability (see instructions)		835,706		2,735,125	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1306

Period:

Worksheet E-1

Component CCN: 14-Z306

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 4:06 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,992,756		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	12/07/2020	134,542		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)		-134,542		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)		1,858,214		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		553,864		0	6.02
7.00	Total Medicare program liability (see instructions)		1,304,350		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/28/2021 4:06 pm

		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: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2	
		Component CCN: 14-Z306		Date/Time Prepared: 7/28/2021 4:06 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,011,771	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		311,981	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		674	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,323,752	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,323,752	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,323,752	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		10,736	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,313,016	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,313,016	0	19.00
19.01	Sequestration adjustment (see instructions)		8,666	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,858,214	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-553,864	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/28/2021 4:06 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		956,424	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)		956,424	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		965,988	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)		965,988	19.00
20.00	Deductibles (exclude professional component)		133,495	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		832,493	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		832,493	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		13,485	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		8,765	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,145	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		841,258	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)		841,258	30.00
30.01	Sequestration adjustment (see instructions)		5,552	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		1,164,797	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)		-329,091	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
7/28/2021 4:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,629,277	0	0	0	1.00
2.00	Temporary investments	22,655	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,513,470	0	0	0	4.00
5.00	Other receivable	1,841,226	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,717,441	0	0	0	6.00
7.00	Inventory	234,278	0	0	0	7.00
8.00	Prepaid expenses	25,990	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,549,455	0	0	0	11.00
FIXED ASSETS						
12.00	Land	546,486	0	0	0	12.00
13.00	Land improvements	2,298,714	0	0	0	13.00
14.00	Accumulated depreciation	-885,217	0	0	0	14.00
15.00	Buildings	8,446,922	0	0	0	15.00
16.00	Accumulated depreciation	-4,204,991	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	9,039,543	0	0	0	19.00
20.00	Accumulated depreciation	-3,468,439	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	2,518,909	0	0	0	23.00
24.00	Accumulated depreciation	-1,649,351	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	669,408	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,311,984	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,199,599	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	496,982	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,696,581	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,558,020	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,308,891	0	0	0	37.00
38.00	Salaries, wages, and fees payable	588,016	0	0	0	38.00
39.00	Payroll taxes payable	20,487	0	0	0	39.00
40.00	Notes and loans payable (short term)	475,196	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	13,282	0	0	0	43.00
44.00	Other current liabilities	6,128,094	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,533,966	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	9,246,297	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	589,709	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,836,006	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,369,972	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,188,048				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,188,048	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,558,020	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/28/2021 4:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,902,456		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,241,081				2.00
3.00	Total (sum of line 1 and line 2)		14,143,537		0		3.00
4.00	CHANGE IN TEMP RESTRICTED ASSETS	44,515		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		44,515		0		10.00
11.00	Subtotal (line 3 plus line 10)		14,188,052		0		11.00
12.00	ROUNDING	4		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)		4		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,188,048		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CHANGE IN TEMP RESTRICTED ASSETS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		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: 14-1306

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 4:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	426,322		426,322	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	484,854		484,854	5.00
6.00	Swing bed - NF	28,023		28,023	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)	939,199		939,199	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	939,199		939,199	17.00
18.00	Ancillary services	3,801,005	24,018,760	27,819,765	18.00
19.00	Outpatient services	375,926	3,374,501	3,750,427	19.00
20.00	RURAL HEALTH CLINIC	0	657,019	657,019	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	106,897	1,203,179	1,310,076	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,223,027	29,253,459	34,476,486	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,407,087		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)		17,407,087		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1306

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/28/2021 4:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,476,486	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,703,424	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,773,062	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,407,087	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,634,025	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	806,222	6.00
7.00	Income from investments	494,330	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	36,649	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	22,488	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	18	16.00
17.00	Revenue from sale of drugs to other than patients	52,897	17.00
18.00	Revenue from sale of medical records and abstracts	4,147	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	29,174	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	23,120	24.00
24.50	COVID-19 PHE Funding	1,462,638	24.50
25.00	Total other income (sum of lines 6-24)	2,931,683	25.00
26.00	Total (line 5 plus line 25)	1,297,658	26.00
27.00	GAIN/LOSS ON ASSET	56,577	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	56,577	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,241,081	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306

Period:

Worksheet M-1

Component CCN: 14-8580

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/28/2021 4:06 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	441,939	0	441,939	-1,725	440,214
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	148,765	0	148,765	-3,210	145,555
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	153,541	153,541
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	590,704	0	590,704	148,606	739,310
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	16,046	16,046	0	16,046
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	31,063	31,063	0	31,063
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	47,109	47,109	0	47,109
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	590,704	47,109	637,813	148,606	786,419
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	8,015	8,015
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	8,015	8,015
FACILITY OVERHEAD						
29.00	Facility Costs	0	11,784	11,784	3,377	15,161
30.00	Administrative Costs	263,178	29,385	292,563	-153,541	139,022
31.00	Total Facility Overhead (sum of lines 29 and 30)	263,178	41,169	304,347	-150,164	154,183
32.00	Total facility costs (sum of lines 22, 28 and 31)	853,882	88,278	942,160	6,457	948,617

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306

Period:

Worksheet M-1

Component CCN: 14-8580

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/28/2021 4:06 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	440,214	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	145,555	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	153,541	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	739,310	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	16,046	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	31,063	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	47,109	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	786,419	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	8,015	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	8,015	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	15,161	29.00
30.00	Administrative Costs	0	139,022	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	154,183	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	948,617	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-1306

Period:

Worksheet M-2

Component CCN:14-8580

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/28/2021 4:06 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.32	2,096	1,554	2,051	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.33	1,977	1,470	1,955	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	4,073		4,006	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.65	4,073		4,073	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)				786,419	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				8,015	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				794,434	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.989911	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				154,183	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				743,427	15.00
16.00	Total overhead (sum of lines 14 and 15)				897,610	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				897,610	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				888,554	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,674,973	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/28/2021 4:06 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,674,973	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			14,831	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,660,142	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,073	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)			4,073	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			407.60	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			407.60	407.60	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,343	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	547,407	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00	
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00	
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	547,407	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			198,933	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			13,675	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			37,630	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.)			391,719	16.04	
16.05	Total program cost (see instructions)		0	429,349	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			20,128	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			32,918	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			429,349	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,689	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			432,038	22.00	
23.00	Allowable bad debts (see instructions)			0	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00	
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50	
25.99	Demonstration payment adjustment amount before sequestration			0	25.99	
26.00	Net reimbursable amount (see instructions)			432,038	26.00	
26.01	Sequestration adjustment (see instructions)			2,851	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			245,944	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)			183,243	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:14-1306 Component CCN:14-8580	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/28/2021 4:06 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		739,310	739,310	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000462	0.001486	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		342	1,099	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,928	2,594	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,270	3,693	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		786,419	786,419	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		888,554	888,554	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004158	0.004696	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,695	4,173	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,965	7,866	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		28	90	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		248.75	87.40	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		8	8	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,990	699	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			14,831	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			2,689	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/28/2021 4:06 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		153,062	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		12/07/2020	92,882	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)		92,882	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		245,944	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		183,243	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		429,187	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00