

State Copy

Health Financial Systems

PINCKNEYVILLE COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

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

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

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

Provider CCN: 14-1307

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

Worksheet S
Parts I-III
Date/Time Prepared:
9/29/2020 1:38 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/29/2020	Time: 1:38 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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PINCKNEYVILLE COMMUNITY HOSPITAL (14-1307) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 9/29/2020 Time: 1:38 pm
kLXSzIoMPOP1bKmxENqREhFXORnLE0
ACF: S0R6.VmNd.Llp9XU.CtJRYCB.B
n6kn0LEXA00b:Y0A
PI: Date: 9/29/2020 Time: 1:38 pm
yaGzhHkfcLXlj3wp0:SS4u1lPaPRN0
0kpp.0cBIP1ElPZNrAZVUEB3U9ShA
bMc70yATCG0ShndF

(Signed)

officer or Administrator of Provider(s)

Chief Financial Officer

Title

09/30/2020

Date

		Title XVIII		HIT	Title XIX	
Title V		Part A	Part B			
1.00		2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	40,903	460,746	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER I					4.00
5.00	Swing Bed - SNF	0	97,519	0	0	5.00
6.00	Swing Bed - NF	0			0	6.00
10.00	RURAL HEALTH CLINIC I	0		106,173	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0	0	11.00
200.00	Total	0	138,422	566,919	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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 1:38 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5383 STATE ROUTE 154			PO Box:				1.00		
2.00	City: PINCKNEYVILLE			State: IL		Zip Code: 62274-1034		County: PERRY		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		PINCKNEYVILLE COMMUNITY HOSPITAL	141307	99914	1	11/30/2000	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		PINCKNEYVILLE CRITICAL ACC SWING BED	14Z307	99914		02/06/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		PINCKNEYVILLE HOSPITAL RHC	143412	99914		03/27/1995	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020		
21.00	Type of Control (see instructions)						11			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	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.							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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 1:38 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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			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.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
				1.00			
				2.00			
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	52,534		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.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 1:38 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			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	
				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: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 1:38 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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part II Date/Time Prepared: 9/29/2020 1:38 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)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/09/2020	Y	09/09/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/29/2020 1:38 pm
	Description	Y/N	Y/N	
	0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
	Y/N	Date	Y/N	Date
	1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	21.00
			1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL	TRACZEK	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6619	PTRACZEK@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/29/2020 1:38 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.	PARTNER	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: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/29/2020 1:38 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	17	6,222	18,480.00	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)		17	6,222	18,480.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		17	6,222	18,480.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		17				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: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/29/2020 1:38 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)	569	30	770		1.00
2.00	HMO and other (see instructions)	52	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	1,121	0	1,244		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	560		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,690	30	2,574		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,690	30	2,574	0.00	169.23
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
26.00	RURAL HEALTH CLINIC	6,216	3,209	17,323	0.00	33.77
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	203.00
28.00	Observation Bed Days		60	414		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/29/2020 1:38 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	172	11	256	1.00
2.00 HMO and other (see instructions)			12	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	172	11	256	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
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: 14-1307 Component CCN: 14-3412		Period: From 05/01/2019 To 04/30/2020		Worksheet S-8 Date/Time Prepared: 9/29/2020 1:38 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				5383 STATE ROUTE 154				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				PINCKNEYVILLE		IL 62274		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:30		19:00		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	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				PERRY				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				19:00		08:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1307 Component CCN: 14-3412		Period: From 05/01/2019 To 04/30/2020		Worksheet S-8 Date/Time Prepared: 9/29/2020 1:38 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			08:30	17:00	09:00	12:00	11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet S-10 Date/Time Prepared: 9/29/2020 1:38 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)			0.550305 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,469,542		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	6,074,228		6.00
7.00	Medicaid cost (line 1 times line 6)	3,342,678		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)	873,136		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	283,862		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	873,136		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)	745,025	637,218	1,382,243 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	409,991	637,218	1,047,209 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)	409,991	637,218	1,047,209 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)	508,106		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	284,783		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	438,129		27.01
28.00	Non-Medicare bad debt expense (see instructions)	69,977		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	191,855		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,239,064		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,112,200		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,865,471	1,865,471	818,402	2,683,873	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG		0	0	3,217	3,217	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG		0	0	35,924	35,924	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG		0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		659,807	659,807	0	659,807	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG		0	0	0	0	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92,261	3,474,132	3,566,393	48,669	3,615,062	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,585,879	1,457,687	3,043,566	-45,231	2,998,335	5.00
6.00	00600	MAINTENANCE & REPAIRS	281,918	608,118	890,036	-6,338	883,698	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,671	94,671	0	94,671	8.00
9.00	00900	HOUSEKEEPING	363,539	69,266	432,805	0	432,805	9.00
10.00	01000	DIETARY	364,950	175,851	540,801	0	540,801	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	467,298	32,036	499,334	0	499,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,899	4,034	42,933	0	42,933	14.00
15.00	01500	PHARMACY	383,565	2,187,763	2,571,328	-36,392	2,534,936	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,210	29,406	362,616	0	362,616	16.00
17.00	01700	SOCIAL SERVICE	41,614	4,576	46,190	0	46,190	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	289,200	289,200	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,690,219	159,623	1,849,842	107,660	1,957,502	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	166,428	174,301	340,729	-49,728	291,001	50.00
53.00	05300	ANESTHESIOLOGY	0	6,435	6,435	0	6,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	484,282	143,276	627,558	3,136	630,694	54.00
54.01	05401	ONCOLOGY	271,827	292,236	564,063	-974	563,089	54.01
56.00	05600	RADIOISOTOPE	77,539	88,896	166,435	0	166,435	56.00
57.00	05700	CT SCAN	59,745	96,282	156,027	0	156,027	57.00
58.00	05800	MRI	0	173,513	173,513	0	173,513	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	576,645	621,367	1,198,012	4,602	1,202,614	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	245,591	54,330	299,921	-1,795	298,216	65.00
66.00	06600	PHYSICAL THERAPY	439,216	50,402	489,618	56,991	546,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,991	10,072	166,063	18,588	184,651	67.00
68.00	06800	SPEECH PATHOLOGY	87,129	8,573	95,702	3,350	99,052	68.00
69.00	06900	ELECTROCARDIOLOGY	2,446	19,594	22,040	0	22,040	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	654	2,329	2,983	0	2,983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	54,297	54,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,068	22,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,823	782,020	792,843	0	792,843	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	194,481	103,881	298,362	0	298,362	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	59,600	59,600	0	59,600	76.02
76.97	07697	CARDIAC REHABILITATION	35,989	23,038	59,027	0	59,027	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,333,068	278,051	2,611,119	-122,850	2,488,269	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,740	134,179	145,919	0	145,919	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	21,369	3,032	24,401	0	24,401	90.01
90.02	04050	TELEMEDICINE	135	400	535	0	535	90.02
91.00	09100	EMERGENCY	532,804	1,706,844	2,239,648	-12,855	2,226,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		815,963	815,963	-815,963	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,351,254	16,760,255	28,111,509	84,868	28,196,377	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	4,332	3,512	7,844	0	7,844	192.00
192.01	19201	FITNESS CENTER	132,215	64,877	197,092	-91,206	105,886	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.04	19204	VACANT SPACE	0	5,254	5,254	6,338	11,592	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		TOTAL (SUM OF LINES 118 through 199)	11,487,801	16,833,898	28,321,699	0	28,321,699	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/29/2020 1:38 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	-205,791	2,478,082	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	3,217	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	35,924	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-30,864	628,943	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6	3,615,056	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-53,103	2,945,232	5.00
6.00	00600	MAINTENANCE & REPAIRS	-34	883,664	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,671	8.00
9.00	00900	HOUSEKEEPING	0	432,805	9.00
10.00	01000	DIETARY	-74,909	465,892	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	499,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-592	42,341	14.00
15.00	01500	PHARMACY	-5,085	2,529,851	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,488	359,128	16.00
17.00	01700	SOCIAL SERVICE	0	46,190	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-149,608	1,807,894	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,344	286,657	50.00
53.00	05300	ANESTHESIOLOGY	0	6,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,756	627,938	54.00
54.01	05401	ONCOLOGY	-264,000	299,089	54.01
56.00	05600	RADIOISOTOPE	0	166,435	56.00
57.00	05700	CT SCAN	0	156,027	57.00
58.00	05800	MRI	0	173,513	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-19,700	1,182,914	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-4,638	293,578	65.00
66.00	06600	PHYSICAL THERAPY	-3,566	543,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	-2,507	182,144	67.00
68.00	06800	SPEECH PATHOLOGY	-23,187	75,865	68.00
69.00	06900	ELECTROCARDIOLOGY	-11,064	10,976	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-792,843	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	298,362	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	76.01
76.02	03030	SLEEP STUDY	-1,000	58,600	76.02
76.97	07697	CARDIAC REHABILITATION	0	59,027	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,030	2,487,239	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-18,014	127,905	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	24,401	90.01
90.02	04050	TELEMEDICINE	0	535	90.02
91.00	09100	EMERGENCY	-581,384	1,645,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,253,513	25,942,864	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,844	192.00
192.01	19201	FITNESS CENTER	0	105,886	192.01
192.02	19202	RETAIL PHARMACY	0	0	192.02
192.03	19203	LEASED SPACE	0	0	192.03
192.04	19204	VACANT SPACE	0	11,592	192.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.05	19205	MEALS ON WHEELS	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	192.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,253,513	26,068,186	200.00

RECLASSIFICATIONS

Provider CCN: 14-1307

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

Worksheet A-6

Date/Time Prepared:
9/29/2020 1:38 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	812,312	1.00	
2.00	LABORATORY	60.00	0	515	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,136	3.00	
	TOTALS		0	815,963		
	B - RECLASS WELLNESS CENTER					
1.00	PHYSICAL THERAPY	66.00	45,862	11,129	1.00	
2.00	OCCUPATIONAL THERAPY	67.00	14,958	3,630	2.00	
3.00	SPEECH PATHOLOGY	68.00	2,696	654	3.00	
4.00	FITNESS CENTER	192.01	480	117	4.00	
	TOTALS		63,996	15,530		
	C - RHC PHYSICIAN					
1.00	ADULTS & PEDIATRICS	30.00	115,279	3,484	1.00	
	TOTALS		115,279	3,484		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	52	1.00	
2.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	35,924	2.00	
	TOTALS		0	35,976		
	E - RHC LAB					
1.00	LABORATORY	60.00	1,804	2,283	1.00	
	TOTALS		1,804	2,283		
	F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,066	1.00	
2.00	NEW CAP REL COSTS-PT BLDG	1.02	0	3,165	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		0	45,231		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	22,068	1.00	
	TOTALS		0	22,068		
	H - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	54,297	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	54,297		
	I - FITNESS CENTER RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,277	1.00	
	TOTALS		0	12,277		
	J - VACANT SPACE RECLASS					
1.00	VACANT SPACE	192.04	0	6,338	1.00	
	TOTALS		0	6,338		
	K - RECLASS EMPLOYEE SCRIPTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	36,392	0	1.00	
	TOTALS		36,392	0		
500.00	Grand Total: Increases		217,471	1,013,447	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1307

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

Worksheet A-6

Date/Time Prepared:
9/29/2020 1:38 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	815,963	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	815,963			
	B - RECLASS WELLNESS CENTER						
1.00	FITNESS CENTER	192.01	63,996	15,530	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		63,996	15,530			
	C - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	115,279	3,484	0		1.00
	TOTALS		115,279	3,484			
	D - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,976	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	35,976			
	E - RHC LAB						
1.00	RURAL HEALTH CLINIC	88.00	1,804	2,283	0		1.00
	TOTALS		1,804	2,283			
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,231	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	45,231			
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	22,068	0		1.00
	TOTALS		0	22,068			
	H - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	11,103	0		1.00
2.00	OPERATING ROOM	50.00	0	27,660	0		2.00
3.00	ONCOLOGY	54.01	0	974	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,705	0		4.00
5.00	EMERGENCY	91.00	0	12,855	0		5.00
	TOTALS		0	54,297			
	I - FITNESS CENTER RECLASS						
1.00	FITNESS CENTER	192.01	0	12,277	0		1.00
	TOTALS		0	12,277			
	J - VACANT SPACE RECLASS						
1.00	MAINTENANCE & REPAIRS	6.00	0	6,338	0		1.00
	TOTALS		0	6,338			
	K - RECLASS EMPLOYEE SCRIPTS						
1.00	PHARMACY	15.00	36,392	0	0		1.00
	TOTALS		36,392	0			
500.00	Grand Total: Decreases		217,471	1,013,447			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/29/2020 1:38 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	522,113	0	0	0	0	1.00	
2.00	Land Improvements	2,925,869	275,699	0	275,699	0	2.00	
3.00	Buildings and Fixtures	29,900,050	4,909,451	0	4,909,451	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	5,819,511	652,964	0	652,964	401,917	6.00	
7.00	HIT designated Assets	1,682,322	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	40,849,865	5,838,114	0	5,838,114	401,917	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	40,849,865	5,838,114	0	5,838,114	401,917	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	522,113	0					1.00
2.00	Land Improvements	3,201,568	0					2.00
3.00	Buildings and Fixtures	34,809,501	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	6,070,558	0					6.00
7.00	HIT designated Assets	1,682,322	0					7.00
8.00	Subtotal (sum of lines 1-7)	46,286,062	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	46,286,062	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/29/2020 1:38 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	1,865,471	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	659,807	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,525,278	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,865,471				1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0				1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0				1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	659,807				2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,525,278				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/29/2020 1:38 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	34,809,501	0	34,809,501	0.817847	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0.000000	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	7,752,881	0	7,752,881	0.182153	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	42,562,382	0	42,562,382	1.000000	0	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	0	1,829,495	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	52	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	35,924	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	628,943	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,494,414	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	606,521	42,066	0	0	2,478,082	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	3,165	0	0	3,217	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0	35,924	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	628,943	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	606,521	45,231	0	0	3,146,166	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:
9/29/2020 1:38 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.	Pm
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-205,791	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-NEW BLDG (chapter 2)		0	NEW CAP REL COSTS-NEW BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-PT BLDG (chapter 2)		0	NEW CAP REL COSTS-PT BLDG	1.02	0	1.02
1.03	Investment income - NEW CAP REL COSTS-RHC BLDG (chapter 2)		0	NEW CAP REL COSTS-RHC BLDG	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-15 N MAIN BLDG (chapter 2)		0	CAP REL COSTS-15 N MAIN BLDG	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP NEW BLDG (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-2,214	PHARMACY	15.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,399	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,028,996			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,393	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,481	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:
9/29/2020 1:38 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 #		
				3.00	4.00	5.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-NEW BLDG			0NEW CAP REL COSTS-NEW BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-PT BLDG			0NEW CAP REL COSTS-PT BLDG	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-RHC BLDG			0NEW CAP REL COSTS-RHC BLDG	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-15 N MAIN BLDG			0CAP REL COSTS-15 N MAIN BLDG	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP NEW BLDG			0CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0	27.01
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-30,864	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NONPATIENT CARE RELATED PROPERTY INS	A	-4,279	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-207	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	AMBULANCE RX	A	-2,871	PHARMACY	15.00	0	34.01
34.02	REBATE - CENTRAL SUPPLY	B	-592	CENTRAL SERVICES & SUPPLY	14.00	0	34.02
34.03	REBATE - DIETARY	B	-1,493	DIETARY	10.00	0	34.03
34.04	NON-ALLOWABLE LOBBYING	A	-7	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
35.00	NON-ALLOWABLE LOBBYING	A	-7	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	MOBILE PET SCAN RENTAL	B	-2,750	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	NON-ALLOWABLE LOBBYING	A	-9,932	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	NON-ALLOWABLE LOBBYING	A	-1	DIETARY	10.00	0	37.01
37.02	NON-ALLOWABLE LOBBYING	A	-34	MAINTENANCE & REPAIRS	6.00	0	37.02
37.03	NON-ALLOWABLE LOBBYING	A	-13	OPERATING ROOM	50.00	0	37.03
37.04	NON-ALLOWABLE LOBBYING	A	-6	RADIOLOGY-DIAGNOSTIC	54.00	0	37.04
37.05	NON-ALLOWABLE LOBBYING	A	-1,030	RURAL HEALTH CLINIC	88.00	0	37.05
37.06	NON-ALLOWABLE LOBBYING	A	-6	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.06
37.07	NON-ALLOWABLE LOBBYING	A	-18	RESPIRATORY THERAPY	65.00	0	37.07
38.00	NON-ALLOWABLE LOBBYING	A	-100	PHYSICAL THERAPY	66.00	0	38.00
39.00	NON-ALLOWABLE ADVERTISING	A	-29,362	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	GIFTS & DONATIONS	A	-1,355	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	UNALLOWABLE TRANSPORT ASSET	A	-1,078	EMERGENCY	91.00	0	41.00
42.00	COMMUNITY EDUCATION	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	OUTSIDE SERVICES - PHYSICAL THERAPY	B	-3,466	PHYSICAL THERAPY	66.00	0	43.00
43.01	OUTSIDE SERVICES - OCCUP THERAPY	B	-2,507	OCCUPATIONAL THERAPY	67.00	0	43.01
43.02	OUTSIDE SERVICES - SPEECH PATHOLOGY	B	-23,187	SPEECH PATHOLOGY	68.00	0	43.02
43.04	OUTSIDE SERVICES - LAB	B	-19,700	LABORATORY	60.00	0	43.04
44.00	LIABILITY CLAIMS	A	-1,069	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	SPECIALTY CLINIC SUPPORT	A	-3,940	CLINIC	90.00	0	45.00
46.00	DIETICIAN'S CONSULTS	B	-22	DIETARY	10.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.00
48.00	340B EXPENSES	A	-792,843	DRUGS CHARGED TO PATIENTS	73.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,253,513				50.00

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

(2) Basis for adjustment (see instructions).

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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:
9/29/2020 1:38 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	2.00	3.00	4.00	5.00

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1307

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

Worksheet A-8-2

Date/Time Prepared:
9/29/2020 1:38 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	DR. F	57,917	57,917	0	0	0	1.00
2.00	30.00	DR. R	35,052	35,052	0	0	0	2.00
3.00	30.00	DR. F	25,794	25,794	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,611,961	580,306	1,031,655	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	30,838	30,838	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	264,000	264,000	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	29,348	0	29,348	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	4,620	4,620	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	1,000	1,000	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	11,064	11,064	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	30,000	0	30,000	0	0	11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	4,331	4,331	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	14,074	14,074	0	0	0	13.00
200.00			2,119,999	1,028,996	1,091,003		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	DR. F	0	0	0	0	0	1.00
2.00	30.00	DR. R	0	0	0	0	0	2.00
3.00	30.00	DR. F	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0	0	11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	13.00
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	DR. F	0	0	0	57,917		1.00
2.00	30.00	DR. R	0	0	0	35,052		2.00
3.00	30.00	DR. F	0	0	0	25,794		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	580,306		4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	30,838		5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	264,000		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	4,620		8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	1,000		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	11,064		10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0		11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	4,331		12.00
13.00	90.00	AGGREGATE-CLINIC	0	0	0	14,074		13.00
200.00			0	0	0	1,028,996		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/29/2020 1:38 pm		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						6	1.00
2.00	Line 1 multiplied by 15 hours per week						90	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						11	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.78	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	44.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	83.88	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)	41.94	41.94	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)						3,691	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)						3,691	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)						3,691	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)						83.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						7,550	22.00
23.00	Total salary equivalency (see instructions)						7,550	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)						461	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)						461	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)						64	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						525	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)						525	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						64	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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/29/2020 1:38 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)	83.88	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)						7,550	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						525	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)						8,075	63.00
64.00	Total cost of outside supplier services (from your records)						2,640	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						461	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						64	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						525	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						64	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						64	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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/29/2020 1:38 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.40	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.20	38.20	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)					344	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)					344	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)					344	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)					76.44	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					1,147	22.00
23.00	Total salary equivalency (see instructions)					1,147	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)					38	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)					38	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)					6	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					44	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)					44	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					6	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: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/29/2020 1:38 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)	76.40	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)						1,147	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						44	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)						1,191	63.00
64.00	Total cost of outside supplier services (from your records)						270	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						38	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						6	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						44	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						6	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						6	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,478,082	2,478,082				1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	3,217	0	0	3,217		1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	35,924	0	0	0	35,924	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	628,943					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,615,056	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,945,232	558,480	0	46	5,937	5.00
6.00	00600	MAINTENANCE & REPAIRS	883,664	173,208	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,671	11,315	0	0	0	8.00
9.00	00900	HOUSEKEEPING	432,805	22,630	0	0	0	9.00
10.00	01000	DIETARY	465,892	106,459	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	499,334	11,103	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,341	36,389	0	0	0	14.00
15.00	01500	PHARMACY	2,529,851	35,858	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	359,128	36,097	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	46,190	2,523	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	289,200	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,807,894	251,272	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	286,657	246,358	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	6,435	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,938	147,284	0	0	0	54.00
54.01	05401	ONCOLOGY	299,089	73,310	0	0	0	54.01
56.00	05600	RADIOISOTOPE	166,435	7,862	0	0	0	56.00
57.00	05700	CT SCAN	156,027	24,198	0	0	0	57.00
58.00	05800	MRI	173,513	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,182,914	71,929	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	293,578	82,713	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	543,043	15,406	0	2,010	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	182,144	2,975	0	319	0	67.00
68.00	06800	SPEECH PATHOLOGY	75,865	744	0	42	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,976	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,983	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,297	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	298,362	74,372	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	58,600	12,989	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	59,027	7,278	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,487,239	265,721	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	127,905	3,453	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	24,401	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	535	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,645,409	156,261	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,942,864	2,438,187	0	2,417	5,937	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,129	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,844	17,902	0	0	0	192.00
192.01	19201	FITNESS CENTER	105,886	9,748	0	16	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	1.03	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	1,116	0	0	0	192.03
192.04	19204	VACANT SPACE	11,592	0	0	784	29,987	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,068,186	2,478,082	0	3,217	35,924	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01		4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		628,943				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG		0	0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	3,615,056		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	152,014	0	511,766	4,173,475	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	40,635	0	90,976	1,188,483	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,655	0	0	108,641	8.00
9.00	00900	HOUSEKEEPING	0	5,309	0	117,315	578,059	9.00
10.00	01000	DIETARY	0	24,975	0	117,770	715,096	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,605	0	150,798	663,840	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,537	0	12,553	99,820	14.00
15.00	01500	PHARMACY	0	8,412	0	112,033	2,686,154	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,468	0	107,528	511,221	16.00
17.00	01700	SOCIAL SERVICE	0	592	0	13,429	62,734	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	58,949	0	545,437	2,663,552	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	57,796	0	53,707	644,518	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,553	0	156,279	966,054	54.00
54.01	05401	ONCOLOGY	0	17,199	0	87,719	477,317	54.01
56.00	05600	RADIOISOTOPE	0	1,844	0	25,022	201,163	56.00
57.00	05700	CT SCAN	0	5,677	0	19,280	205,182	57.00
58.00	05800	MRI	0	0	0	0	173,513	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	16,875	0	186,667	1,458,385	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	19,404	0	79,253	474,948	65.00
66.00	06600	PHYSICAL THERAPY	0	34,079	0	156,536	751,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,540	0	55,166	246,144	67.00
68.00	06800	SPEECH PATHOLOGY	0	816	0	28,987	106,454	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	789	11,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	211	3,194	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	17,448	0	62,759	452,941	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	3,047	0	0	74,636	76.02
76.97	07697	CARDIAC REHABILITATION	0	1,707	0	11,614	79,626	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	62,338	0	715,095	3,530,393	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	810	0	323	132,491	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	6,896	31,297	90.01
90.02	04050	TELEMEDICINE	0	0	0	44	579	90.02
91.00	09100	EMERGENCY	0	36,659	0	171,937	2,010,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	628,943	0	3,597,889	25,855,015	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	11,129	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,398	27,144	192.00
192.01	19201	FITNESS CENTER	0	0	0	15,769	131,419	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	1,116	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01		4A	
192.04	19204	VACANT SPACE	0	0	0	0	42,363	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	628,943	0	3,615,056	26,068,186	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE E & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,173,475					5.00
6.00	00600	MAINTENANCE & REPAIRS	226,982	1,415,465				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,749	8,475	137,865			8.00
9.00	00900	HOUSEKEEPING	110,401	16,950	0	705,410		9.00
10.00	01000	DIETARY	136,573	79,739	0	54,493	985,901	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	126,783	8,316	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,064	27,256	0	0	0	14.00
15.00	01500	PHARMACY	513,015	26,858	0	9,999	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,636	27,037	0	4,999	0	16.00
17.00	01700	SOCIAL SERVICE	11,981	1,890	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	55,233	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	508,698	188,206	137,865	173,976	985,901	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	123,093	184,526	0	50,494	0	50.00
53.00	05300	ANESTHESIOLOGY	1,229	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,502	110,317	0	40,995	0	54.00
54.01	05401	ONCOLOGY	91,160	54,910	0	34,496	0	54.01
56.00	05600	RADIOISOTOPE	38,419	5,889	0	0	0	56.00
57.00	05700	CT SCAN	39,187	18,124	0	0	0	57.00
58.00	05800	MRI	33,138	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	278,530	53,875	0	35,495	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	90,708	61,953	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	143,444	108,805	0	47,994	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	47,010	17,687	0	8,499	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,331	2,606	0	1,500	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,247	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	610	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,370	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,215	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	86,505	55,706	0	27,496	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	14,254	9,729	0	2,500	0	76.02
76.97	07697	CARDIAC REHABILITATION	15,207	5,451	0	3,000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	674,257	199,031	0	85,989	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	25,304	2,586	0	34,496	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	5,977	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	111	0	0	0	0	90.02
91.00	09100	EMERGENCY	383,931	117,042	0	70,991	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,140,854	1,392,964	137,865	687,412	985,901	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,125	8,336	0	500	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,184	13,409	0	0	0	192.00
192.01	19201	FITNESS CENTER	25,099	756	0	15,498	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	213	0	0	2,000	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

 Period:
 From 05/01/2019
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
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)	4,173,475	1,415,465	137,865	705,410	985,901	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	798,939				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	146,140			14.00
15.00	01500	PHARMACY	0	0	3,724	3,239,750		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	366	0	641,259	16.00
17.00	01700	SOCIAL SERVICE	0	0	5	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	488,598	12,319	0	26,656	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	53,189	5,417	0	10,885	50.00
53.00	05300	ANESTHESIOLOGY	0	0	362	0	8,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,767	0	45,928	54.00
54.01	05401	ONCOLOGY	0	86,873	2,927	0	8,612	54.01
56.00	05600	RADIOISOTOPE	0	0	10	0	6,778	56.00
57.00	05700	CT SCAN	0	0	2,473	0	86,184	57.00
58.00	05800	MRI	0	0	618	0	19,053	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	50,062	0	122,428	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	2,234	0	7,422	65.00
66.00	06600	PHYSICAL THERAPY	0	0	808	0	38,420	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	81	0	12,461	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	96	0	4,120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	234	0	62	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	36,027	0	4,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,473	0	751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,239,750	120,919	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	290	0	12,058	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	10,767	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	6,506	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	51	0	2,394	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	9,013	0	41,520	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	11	0	4,839	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	477	0	2,628	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	28	90.02
91.00	09100	EMERGENCY	0	170,279	8,925	0	34,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	798,939	145,770	3,239,750	641,259	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	2	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	128	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	240	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

 Worksheet B
 Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	192.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	798,939	146,140	3,239,750	641,259 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
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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
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	76,610					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	344,433				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,610	0	5,262,381	-55,699	5,206,682	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,072,122	0	1,072,122	50.00
53.00	05300	ANESTHESIOLOGY	0	344,433	361,172	0	361,172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,353,563	0	1,353,563	54.00
54.01	05401	ONCOLOGY	0	0	756,295	0	756,295	54.01
56.00	05600	RADIOISOTOPE	0	0	252,259	0	252,259	56.00
57.00	05700	CT SCAN	0	0	351,150	0	351,150	57.00
58.00	05800	MRI	0	0	226,322	0	226,322	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,998,775	0	1,998,775	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	637,265	0	637,265	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,090,545	0	1,090,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	331,882	0	331,882	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	132,792	0	132,792	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,228	0	18,228	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4,100	0	4,100	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	105,064	0	105,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30,507	0	30,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,360,669	0	3,360,669	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	634,996	0	634,996	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	10,767	55,699	66,466	76.01
76.02	03030	SLEEP STUDY	0	0	107,625	0	107,625	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	105,729	0	105,729	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	4,540,203	0	4,540,203	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	199,727	0	199,727	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	40,379	0	40,379	90.01
90.02	04050	TELEMEDICINE	0	0	718	0	718	90.02
91.00	09100	EMERGENCY	0	0	2,796,290	0	2,796,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,610	344,433	25,781,525	0	25,781,525	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,090	0	22,090	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	45,739	0	45,739	192.00
192.01	19201	FITNESS CENTER	0	0	172,900	0	172,900	192.01
192.02	19202	RETAIL PHARMACY	0	0	240	0	240	192.02
192.03	19203	LEASED SPACE	0	0	3,329	0	3,329	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

 Worksheet B
 Part I
 Date/Time Prepared:
 9/29/2020 1:38 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	
192.04	19204	VACANT SPACE	0	0	42,363	0	42,363	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,610	344,433	26,068,186	0	26,068,186	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
0			1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02	
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03	
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	0	558,480	0	46	5,937	
6.00	00600	MAINTENANCE & REPAIRS	0	173,208	0	0	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,315	0	0	8.00	
9.00	00900	HOUSEKEEPING	0	22,630	0	0	9.00	
10.00	01000	DIETARY	0	106,459	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	11,103	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,389	0	0	14.00	
15.00	01500	PHARMACY	0	35,858	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,097	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	2,523	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	251,272	0	0	30.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	246,358	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,284	0	0	54.00	
54.01	05401	ONCOLOGY	0	73,310	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	7,862	0	0	56.00	
57.00	05700	CT SCAN	0	24,198	0	0	57.00	
58.00	05800	MRI	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	71,929	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	82,713	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	15,406	0	2,010	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	2,975	0	319	67.00	
68.00	06800	SPEECH PATHOLOGY	0	744	0	42	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03950	SENIOR LIFE SOLUTIONS	0	74,372	0	0	76.00	
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	76.01	
76.02	03030	SLEEP STUDY	0	12,989	0	0	76.02	
76.97	07697	CARDIAC REHABILITATION	0	7,278	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	265,721	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	3,453	0	0	90.00	
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	90.01	
90.02	04050	TELEMEDICINE	0	0	0	0	90.02	
91.00	09100	EMERGENCY	0	156,261	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,438,187	0	2,417	5,937	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,129	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,902	0	0	192.00	
192.01	19201	FITNESS CENTER	0	9,748	0	16	192.01	
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

 Worksheet B
 Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	1.03	
192.03	19203	LEASED SPACE	0	1,116	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	784	29,987	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,478,082	0	3,217	35,924	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	152,014	0	716,477	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	40,635	0	213,843	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,655	0	13,970	0	8.00
9.00	00900	HOUSEKEEPING	0	5,309	0	27,939	0	9.00
10.00	01000	DIETARY	0	24,975	0	131,434	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,605	0	13,708	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,537	0	44,926	0	14.00
15.00	01500	PHARMACY	0	8,412	0	44,270	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,468	0	44,565	0	16.00
17.00	01700	SOCIAL SERVICE	0	592	0	3,115	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	58,949	0	310,221	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	57,796	0	304,154	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,553	0	181,837	0	54.00
54.01	05401	ONCOLOGY	0	17,199	0	90,509	0	54.01
56.00	05600	RADIOISOTOPE	0	1,844	0	9,706	0	56.00
57.00	05700	CT SCAN	0	5,677	0	29,875	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	16,875	0	88,804	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	19,404	0	102,117	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,079	0	51,495	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,540	0	8,834	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	816	0	1,602	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	17,448	0	91,820	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	3,047	0	16,036	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	1,707	0	8,985	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	62,338	0	328,059	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	810	0	4,263	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	36,659	0	192,920	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	628,943	0	3,075,484	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,129	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	17,902	0	192.00
192.01	19201	FITNESS CENTER	0	0	0	9,764	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	1,116	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

 Worksheet B
 Part II
 Date/Time Prepared:
 9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01	2A	4.00	
192.04	19204	VACANT SPACE	0	0	0	30,771	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	628,943	0	3,146,166	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE E & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	716,477					5.00
6.00	00600	MAINTENANCE & REPAIRS	38,967	252,810				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,562	1,514	19,046			8.00
9.00	00900	HOUSEKEEPING	18,953	3,027	0	49,919		9.00
10.00	01000	DIETARY	23,446	14,242	0	3,856	172,978	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,765	1,485	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,273	4,868	0	0	0	14.00
15.00	01500	PHARMACY	88,071	4,797	0	708	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,761	4,829	0	354	0	16.00
17.00	01700	SOCIAL SERVICE	2,057	338	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	9,482	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,330	33,615	19,046	12,312	172,978	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,132	32,957	0	3,573	0	50.00
53.00	05300	ANESTHESIOLOGY	211	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,674	19,703	0	2,901	0	54.00
54.01	05401	ONCOLOGY	15,650	9,807	0	2,441	0	54.01
56.00	05600	RADIOISOTOPE	6,596	1,052	0	0	0	56.00
57.00	05700	CT SCAN	6,727	3,237	0	0	0	57.00
58.00	05800	MRI	5,689	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	47,816	9,622	0	2,512	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	15,572	11,065	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,625	19,433	0	3,396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,070	3,159	0	601	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,490	465	0	106	0	68.00
69.00	06900	ELECTROCARDIOLOGY	386	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,780	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	724	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	14,851	9,949	0	1,946	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	2,447	1,738	0	177	0	76.02
76.97	07697	CARDIAC REHABILITATION	2,611	974	0	212	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	115,753	35,549	0	6,085	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,344	462	0	2,441	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	1,026	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	19	0	0	0	0	90.02
91.00	09100	EMERGENCY	65,911	20,904	0	5,024	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	710,876	248,791	19,046	48,645	172,978	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	365	1,489	0	35	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	890	2,395	0	0	0	192.00
192.01	19201	FITNESS CENTER	4,309	135	0	1,097	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	37	0	0	142	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
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)	716,477	252,810	19,046	49,919	172,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	36,958				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	53,067			14.00
15.00	01500	PHARMACY	0	0	1,352	139,198		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	133	0	66,642	16.00
17.00	01700	SOCIAL SERVICE	0	0	2	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	22,602	4,473	0	2,769	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,460	1,967	0	1,131	50.00
53.00	05300	ANESTHESIOLOGY	0	0	131	0	905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,094	0	4,771	54.00
54.01	05401	ONCOLOGY	0	4,019	1,063	0	895	54.01
56.00	05600	RADIOISOTOPE	0	0	4	0	704	56.00
57.00	05700	CT SCAN	0	0	898	0	8,953	57.00
58.00	05800	MRI	0	0	225	0	1,979	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	18,179	0	12,743	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	811	0	771	65.00
66.00	06600	PHYSICAL THERAPY	0	0	293	0	3,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	29	0	1,295	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	197	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	35	0	428	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	85	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,082	0	454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,261	0	78	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	139,198	12,562	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	105	0	1,253	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	1,119	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	676	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	19	0	249	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,273	0	4,313	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	4	0	503	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	173	0	273	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	3	90.02
91.00	09100	EMERGENCY	0	7,877	3,241	0	3,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	36,958	52,932	139,198	66,642	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	1	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	47	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	87	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	36,958	53,067	139,198	66,642	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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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
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	5,512					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	9,482				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,512		670,858	0	670,858	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		367,374	0	367,374	50.00
53.00	05300	ANESTHESIOLOGY	0		1,247	0	1,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		242,980	0	242,980	54.00
54.01	05401	ONCOLOGY	0		124,384	0	124,384	54.01
56.00	05600	RADIOISOTOPE	0		18,062	0	18,062	56.00
57.00	05700	CT SCAN	0		49,690	0	49,690	57.00
58.00	05800	MRI	0		7,893	0	7,893	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		179,676	0	179,676	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0		130,336	0	130,336	65.00
66.00	06600	PHYSICAL THERAPY	0		103,233	0	103,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		21,988	0	21,988	67.00
68.00	06800	SPEECH PATHOLOGY	0		5,860	0	5,860	68.00
69.00	06900	ELECTROCARDIOLOGY	0		849	0	849	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		196	0	196	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		15,316	0	15,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		2,063	0	2,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		151,760	0	151,760	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0		119,924	0	119,924	76.00
76.01	03020	OP IV THERAPY/NURSING	0		1,119	0	1,119	76.01
76.02	03030	SLEEP STUDY	0		21,074	0	21,074	76.02
76.97	07697	CARDIAC REHABILITATION	0		13,050	0	13,050	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		493,032	0	493,032	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		12,017	0	12,017	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0		1,472	0	1,472	90.01
90.02	04050	TELEMEDICINE	0		22	0	22	90.02
91.00	09100	EMERGENCY	0		299,498	0	299,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,512	0	3,054,973	0	3,054,973	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		13,018	0	13,018	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		21,188	0	21,188	192.00
192.01	19201	FITNESS CENTER	0		15,352	0	15,352	192.01
192.02	19202	RETAIL PHARMACY	0		87	0	87	192.02
192.03	19203	LEASED SPACE	0		1,295	0	1,295	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/29/2020 1:38 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	
192.04	19204	VACANT SPACE	0		30,771	0	30,771	192.04
192.05	19205	MEALS ON WHEELS	0		0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0		0	0	0	192.06
200.00		Cross Foot Adjustments		9,482	9,482	0	9,482	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,512	9,482	3,146,166	0	3,146,166	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	93,296					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0		7,828			1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	0	0	19,702		1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	406	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,026	0	113	3,256	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,521	0	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	852	0	0	0	0	9.00
10.00	01000	DIETARY	4,008	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	0	0	0	14.00
15.00	01500	PHARMACY	1,350	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	95	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,460	0	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,275	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	0	0	0	54.00
54.01	05401	ONCOLOGY	2,760	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	296	0	0	0	0	56.00
57.00	05700	CT SCAN	911	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,114	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	580	0	4,889	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	112	0	777	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28	0	103	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	2,800	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	489	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	274	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,004	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	130	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,794	0	5,882	3,256	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	419	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	674	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	367	0	38	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	42	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
192.04	19204	VACANT SPACE	0	0	1,908	16,446	406	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,478,082	0	3,217	35,924	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.561503	0.000000	0.410961	1.823368	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
			2.00	2.01	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	100,932					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,202,474			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,395	0	1,585,879	-4,173,475	21,852,348	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,521	0	281,918	0	1,188,483	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	108,641	8.00
9.00	00900	HOUSEKEEPING	852	0	363,539	0	578,059	9.00
10.00	01000	DIETARY	4,008	0	364,950	0	715,096	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	467,298	0	663,840	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	38,899	0	99,820	14.00
15.00	01500	PHARMACY	1,350	0	347,173	0	2,686,154	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	333,210	0	511,221	16.00
17.00	01700	SOCIAL SERVICE	95	0	41,614	0	62,734	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,460	0	1,690,219	0	2,663,552	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,275	0	166,428	0	644,518	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	484,282	0	966,054	54.00
54.01	05401	ONCOLOGY	2,760	0	271,827	0	477,317	54.01
56.00	05600	RADIOISOTOPE	296	0	77,539	0	201,163	56.00
57.00	05700	CT SCAN	911	0	59,745	0	205,182	57.00
58.00	05800	MRI	0	0	0	0	173,513	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	578,449	0	1,458,385	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,114	0	245,591	0	474,948	65.00
66.00	06600	PHYSICAL THERAPY	5,469	0	485,078	0	751,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	889	0	170,949	0	246,144	67.00
68.00	06800	SPEECH PATHOLOGY	131	0	89,825	0	106,454	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,446	0	11,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	654	0	3,194	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	2,800	0	194,481	0	452,941	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	489	0	0	0	74,636	76.02
76.97	07697	CARDIAC REHABILITATION	274	0	35,989	0	79,626	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,004	0	2,215,985	0	3,530,393	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	130	0	1,000	0	132,491	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	21,369	0	31,297	90.01
90.02	04050	TELEMEDICINE	0	0	135	0	579	90.02
91.00	09100	EMERGENCY	5,883	0	532,804	0	2,010,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,932	0	11,149,275	-4,173,475	21,681,540	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	11,129	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,332	0	27,144	192.00
192.01	19201	FITNESS CENTER	0	0	48,867	0	131,419	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
			2.00	2.01	4.00	5A	5.00	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	1,116	192.03
192.04	19204	VACANT SPACE	0	0	0	-42,363	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	628,943	0	3,615,056		4,173,475	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.231354	0.000000	0.322702		0.190985	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		716,477	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.032787	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: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DA YS)	CAFETERIA (SALARIES)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	71,147				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	2,574			8.00
9.00	00900	HOUSEKEEPING	852	0	1,411		9.00
10.00	01000	DIETARY	4,008	0	109	2,574	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	0	0	14.00
15.00	01500	PHARMACY	1,350	0	20	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	10	0	16.00
17.00	01700	SOCIAL SERVICE	95	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	9,460	2,574	348	2,574	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,275	0	101	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	82	0	54.00
54.01	05401	ONCOLOGY	2,760	0	69	0	54.01
56.00	05600	RADIOISOTOPE	296	0	0	0	56.00
57.00	05700	CT SCAN	911	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	71	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,114	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,469	0	96	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	889	0	17	0	67.00
68.00	06800	SPEECH PATHOLOGY	131	0	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	2,800	0	55	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	489	0	5	0	76.02
76.97	07697	CARDIAC REHABILITATION	274	0	6	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,004	0	172	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	130	0	69	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	142	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,016	2,574	1,375	2,574	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	419	0	1	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	674	0	0	0	192.00
192.01	19201	FITNESS CENTER	38	0	31	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	4	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DA YS)	CAFETERIA (SALARIES)	
			6.00	8.00	9.00	10.00	11.00	
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	1,415,465	137,865	705,410	985,901	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.894936	53.560606	499.936215	383.022922	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	252,810	19,046	49,919	172,978	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.553347	7.399378	35.378455	67.202020	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			NURSING ADMINISTRATIO N (NURSING SA LARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATI ENT REVENUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	2,499,881					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	928,582				14.00
15.00	01500	PHARMACY	0	23,663	2,090,341			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,323	0	46,849,530		16.00
17.00	01700	SOCIAL SERVICE	0	30	0	0	2,574	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,528,822	78,277	0	1,947,429	2,574	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	166,428	34,422	0	795,211	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,297	0	636,512	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,641	0	3,355,369	0	54.00
54.01	05401	ONCOLOGY	271,827	18,600	0	629,144	0	54.01
56.00	05600	RADIOISOTOPE	0	63	0	495,162	0	56.00
57.00	05700	CT SCAN	0	15,714	0	6,296,341	0	57.00
58.00	05800	MRI	0	3,929	0	1,391,985	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	318,090	0	8,945,392	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	14,195	0	542,249	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,132	0	2,806,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	515	0	910,395	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	138,874	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	610	0	300,983	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,489	0	4,509	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	228,920	0	319,275	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,068	0	54,885	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,090,341	8,833,934	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	1,844	0	880,883	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	786,573	0	76.01
76.02	03030	SLEEP STUDY	0	0	0	475,318	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	326	0	174,916	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	57,270	0	3,033,295	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	69	0	353,512	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	3,032	0	191,978	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	2,048	0	90.02
91.00	09100	EMERGENCY	532,804	56,713	0	2,546,492	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,499,881	926,232	2,090,341	46,849,530	2,574	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	13	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	815	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	1,522	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			NURSING ADMINISTRATIO N (NURSING SA LARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATI ENT REVENUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	798,939	146,140	3,239,750	641,259	76,610	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.319591	0.157380	1.549867	0.013688	29.763015	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,958	53,067	139,198	66,642	5,512	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014784	0.057148	0.066591	0.001422	2.141414	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: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
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
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ONCOLOGY	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	76.00
76.01	03020	OP IV THERAPY/NURSING	76.01
76.02	03030	SLEEP STUDY	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	90.01
90.02	04050	TELEMEDICINE	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
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
192.01	19201	FITNESS CENTER	192.01
192.02	19202	RETAIL PHARMACY	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	VACANT SPACE	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
192.05	19205	MEALS ON WHEELS	0	192.05
192.06	19206	15 N MAIN BUILDING	0	192.06
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)	344,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,444.330000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,482	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	94.820000	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

POST STEPDOWN ADJUSTMENTS

Provider CCN: 14-1307

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

Worksheet B-2

Date/Time Prepared:
9/29/2020 1:38 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		RECLASS OP NURSING PROC DONE IN IP		1	76.01	55,699
8.00		RECLASS OP NURSING PROC DONE IN OP		1	30.00	-55,699

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 1:38 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	5,206,682		5,206,682	0
41.00	04100	SUBPROVIDER - IRF	0		0	0
42.00	04200	SUBPROVIDER	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,072,122		1,072,122	0
53.00	05300	ANESTHESIOLOGY	361,172		361,172	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,353,563		1,353,563	0
54.01	05401	ONCOLOGY	756,295		756,295	0
56.00	05600	RADIOISOTOPE	252,259		252,259	0
57.00	05700	CT SCAN	351,150		351,150	0
58.00	05800	MRI	226,322		226,322	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	1,998,775		1,998,775	0
60.01	06001	BLOOD LABORATORY	0		0	0
65.00	06500	RESPIRATORY THERAPY	637,265	0	637,265	0
66.00	06600	PHYSICAL THERAPY	1,090,545	0	1,090,545	0
67.00	06700	OCCUPATIONAL THERAPY	331,882	0	331,882	0
68.00	06800	SPEECH PATHOLOGY	132,792	0	132,792	0
69.00	06900	ELECTROCARDIOLOGY	18,228		18,228	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4,100		4,100	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,064		105,064	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,507		30,507	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,360,669		3,360,669	0
76.00	03950	SENIOR LIFE SOLUTIONS	634,996		634,996	0
76.01	03020	OP IV THERAPY/NURSING	66,466		66,466	0
76.02	03030	SLEEP STUDY	107,625		107,625	0
76.97	07697	CARDIAC REHABILITATION	105,729		105,729	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,540,203		4,540,203	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0
90.00	09000	CLINIC	199,727		199,727	0
90.01	09002	COUMADIN, CHF/COPD CLINIC	40,379		40,379	0
90.02	04050	TELEMEDICINE	718		718	0
91.00	09100	EMERGENCY	2,796,290		2,796,290	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	872,265		872,265	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	26,653,790	0	26,653,790	0
201.00		Less Observation Beds	872,265		872,265	0
202.00		Total (see instructions)	25,781,525	0	25,781,525	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 1:38 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	1,417,466		1,417,466		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	795,211	795,211	1.348223	50.00
53.00	05300	ANESTHESIOLOGY	1,577	634,935	636,512	0.567424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,611	3,186,758	3,355,369	0.403402	54.00
54.01	05401	ONCOLOGY	63	629,081	629,144	1.202102	54.01
56.00	05600	RADIOISOTOPE	35,099	460,063	495,162	0.509447	56.00
57.00	05700	CT SCAN	278,787	6,017,554	6,296,341	0.055770	57.00
58.00	05800	MRI	40,419	1,351,566	1,391,985	0.162589	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	585,628	8,359,764	8,945,392	0.223442	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	145,719	396,530	542,249	1.175226	65.00
66.00	06600	PHYSICAL THERAPY	397,759	2,409,107	2,806,866	0.388528	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,007	617,388	910,395	0.364547	67.00
68.00	06800	SPEECH PATHOLOGY	32,973	105,901	138,874	0.956205	68.00
69.00	06900	ELECTROCARDIOLOGY	10,474	290,509	300,983	0.060562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,509	4,509	0.909293	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	156,038	163,237	319,275	0.329071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54,885	54,885	0.555835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,735	8,195,199	8,833,934	0.380427	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	880,883	880,883	0.720863	76.00
76.01	03020	OP IV THERAPY/NURSING	0	786,573	786,573	0.084501	76.01
76.02	03030	SLEEP STUDY	0	475,318	475,318	0.226427	76.02
76.97	07697	CARDIAC REHABILITATION	0	174,916	174,916	0.604456	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,033,295	3,033,295		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	4,168	349,344	353,512	0.564979	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	191,978	191,978	0.210331	90.01
90.02	04050	TELEMEDICINE	0	2,048	2,048	0.350586	90.02
91.00	09100	EMERGENCY	68,333	2,478,159	2,546,492	1.098095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	529,963	529,963	1.645898	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,274,856	42,574,674	46,849,530		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,274,856	42,574,674	46,849,530		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 1:38 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
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ONCOLOGY	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000			76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000			76.01
76.02	03030	SLEEP STUDY	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.000000			90.01
90.02	04050	TELEMEDICINE	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet C Part I Date/Time Prepared: 9/29/2020 1:38 pm	
				Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,206,682		5,206,682	0	5,206,682
41.00	04100	SUBPROVIDER - IRF	0		0	0	0
42.00	04200	SUBPROVIDER	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,072,122		1,072,122	0	1,072,122
53.00	05300	ANESTHESIOLOGY	361,172		361,172	0	361,172
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,353,563		1,353,563	0	1,353,563
54.01	05401	ONCOLOGY	756,295		756,295	0	756,295
56.00	05600	RADIOISOTOPE	252,259		252,259	0	252,259
57.00	05700	CT SCAN	351,150		351,150	0	351,150
58.00	05800	MRI	226,322		226,322	0	226,322
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	1,998,775		1,998,775	0	1,998,775
60.01	06001	BLOOD LABORATORY	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	637,265	0	637,265	0	637,265
66.00	06600	PHYSICAL THERAPY	1,090,545	0	1,090,545	0	1,090,545
67.00	06700	OCCUPATIONAL THERAPY	331,882	0	331,882	0	331,882
68.00	06800	SPEECH PATHOLOGY	132,792	0	132,792	0	132,792
69.00	06900	ELECTROCARDIOLOGY	18,228		18,228	0	18,228
70.00	07000	ELECTROENCEPHALOGRAPHY	4,100		4,100	0	4,100
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,064		105,064	0	105,064
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,507		30,507	0	30,507
73.00	07300	DRUGS CHARGED TO PATIENTS	3,360,669		3,360,669	0	3,360,669
76.00	03950	SENIOR LIFE SOLUTIONS	634,996		634,996	0	634,996
76.01	03020	OP IV THERAPY/NURSING	66,466		66,466	0	66,466
76.02	03030	SLEEP STUDY	107,625		107,625	0	107,625
76.97	07697	CARDIAC REHABILITATION	105,729		105,729	0	105,729
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,540,203		4,540,203	0	4,540,203
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	199,727		199,727	0	199,727
90.01	09002	COUMADIN, CHF/COPD CLINIC	40,379		40,379	0	40,379
90.02	04050	TELEMEDICINE	718		718	0	718
91.00	09100	EMERGENCY	2,796,290		2,796,290	0	2,796,290
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	872,265		872,265	0	872,265
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0		0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0		0
110.00	11000	INTESTINAL ACQUISITION	0		0		0
111.00	11100	ISLET ACQUISITION	0		0		0
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	26,653,790	0	26,653,790	0	26,653,790
201.00		Less Observation Beds	872,265		872,265		872,265
202.00		Total (see instructions)	25,781,525	0	25,781,525	0	25,781,525

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 1:38 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,417,466		1,417,466		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	795,211	795,211	1.348223	50.00
53.00	05300	ANESTHESIOLOGY	1,577	634,935	636,512	0.567424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,611	3,186,758	3,355,369	0.403402	54.00
54.01	05401	ONCOLOGY	63	629,081	629,144	1.202102	54.01
56.00	05600	RADIOISOTOPE	35,099	460,063	495,162	0.509447	56.00
57.00	05700	CT SCAN	278,787	6,017,554	6,296,341	0.055770	57.00
58.00	05800	MRI	40,419	1,351,566	1,391,985	0.162589	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	585,628	8,359,764	8,945,392	0.223442	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	145,719	396,530	542,249	1.175226	65.00
66.00	06600	PHYSICAL THERAPY	397,759	2,409,107	2,806,866	0.388528	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,007	617,388	910,395	0.364547	67.00
68.00	06800	SPEECH PATHOLOGY	32,973	105,901	138,874	0.956205	68.00
69.00	06900	ELECTROCARDIOLOGY	10,474	290,509	300,983	0.060562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,509	4,509	0.909293	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	156,038	163,237	319,275	0.329071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54,885	54,885	0.555835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,735	8,195,199	8,833,934	0.380427	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	880,883	880,883	0.720863	76.00
76.01	03020	OP IV THERAPY/NURSING	0	786,573	786,573	0.084501	76.01
76.02	03030	SLEEP STUDY	0	475,318	475,318	0.226427	76.02
76.97	07697	CARDIAC REHABILITATION	0	174,916	174,916	0.604456	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,033,295	3,033,295	1.496789	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	4,168	349,344	353,512	0.564979	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	191,978	191,978	0.210331	90.01
90.02	04050	TELEMEDICINE	0	2,048	2,048	0.350586	90.02
91.00	09100	EMERGENCY	68,333	2,478,159	2,546,492	1.098095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	529,963	529,963	1.645898	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,274,856	42,574,674	46,849,530		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,274,856	42,574,674	46,849,530		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ONCOLOGY	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000			76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000			76.01
76.02	03030	SLEEP STUDY	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.000000			90.01
90.02	04050	TELEMEDICINE	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	367,374	795,211	0.461983	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1,247	636,512	0.001959	1,052	2	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	242,980	3,355,369	0.072415	86,981	6,299	54.00
54.01	05401 ONCOLOGY	124,384	629,144	0.197704	16	3	54.01
56.00	05600 RADIOISOTOPE	18,062	495,162	0.036477	18,762	684	56.00
57.00	05700 CT SCAN	49,690	6,296,341	0.007892	153,852	1,214	57.00
58.00	05800 MRI	7,893	1,391,985	0.005670	16,701	95	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	179,676	8,945,392	0.020086	253,270	5,087	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	130,336	542,249	0.240362	64,900	15,599	65.00
66.00	06600 PHYSICAL THERAPY	103,233	2,806,866	0.036779	19,984	735	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,988	910,395	0.024152	16,805	406	67.00
68.00	06800 SPEECH PATHOLOGY	5,860	138,874	0.042197	4,042	171	68.00
69.00	06900 ELECTROCARDIOLOGY	849	300,983	0.002821	4,594	13	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	196	4,509	0.043469	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,316	319,275	0.047971	55,502	2,662	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,063	54,885	0.037588	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	151,760	8,833,934	0.017179	176,401	3,030	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	119,924	880,883	0.136141	0	0	76.00
76.01	03020 OP IV THERAPY/NURSING	1,119	786,573	0.001423	0	0	76.01
76.02	03030 SLEEP STUDY	21,074	475,318	0.044337	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	13,050	174,916	0.074607	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	493,032	3,033,295	0.162540	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	12,017	353,512	0.033993	0	0	90.00
90.01	09002 COUMADIN, CHF/COPD CLINIC	1,472	191,978	0.007668	0	0	90.01
90.02	04050 TELEMEDICINE	22	2,048	0.010742	0	0	90.02
91.00	09100 EMERGENCY	299,498	2,546,492	0.117612	49	6	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	112,388	529,963	0.212068	0	0	92.00
200.00	Total (lines 50 through 199)	2,496,503	45,432,064		872,911	36,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/29/2020 1:38 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
53.00	05300	ANESTHESIOLOGY	344,433	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
54.01	05401	ONCOLOGY	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
60.01	06001	BLOOD LABORATORY	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	0
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0
76.02	03030	SLEEP STUDY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	0	0	0
90.02	04050	TELEMEDICINE	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)	344,433	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			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	795,211	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	344,433	0	636,512	0.541126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,355,369	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	629,144	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	495,162	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,296,341	0.000000	57.00
58.00	05800	MRI	0	0	0	1,391,985	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	8,945,392	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	542,249	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,806,866	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	910,395	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	138,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	300,983	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,509	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	54,885	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,833,934	0.000000	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	880,883	0.000000	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	786,573	0.000000	76.01
76.02	03030	SLEEP STUDY	0	0	0	475,318	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	174,916	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,033,295	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	353,512	0.000000	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	0	191,978	0.000000	90.01
90.02	04050	TELEMEDICINE	0	0	0	2,048	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,546,492	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	529,963	0.000000	92.00
200.00		Total (lines 50 through 199)	0	344,433	0	45,432,064		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/29/2020 1:38 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
53.00	05300	ANESTHESIOLOGY	0.000000	1,052	569	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	86,981	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	16	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	18,762	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	153,852	0	0	0	57.00
58.00	05800	MRI	0.000000	16,701	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	253,270	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	64,900	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,984	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	16,805	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,042	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,594	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	55,502	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	176,401	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.000000	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	49	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)		872,911	569	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 1:38 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1.348223	0	462,963	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	0	351,136	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	0	1,436,351	0	0	0	54.00
54.01	05401	ONCOLOGY	1.202102	0	384,698	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.509447	0	246,756	0	0	0	56.00
57.00	05700	CT SCAN	0.055770	0	2,758,997	0	0	0	57.00
58.00	05800	MRI	0.162589	0	575,907	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.223442	0	3,898,278	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	0	190,028	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	0	931,401	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	0	233,040	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	0	21,217	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	0	156,371	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	1,879	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	0	77,198	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	38,464	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	0	5,299,681	701	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	877,854	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	409,844	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	155,490	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	120,258	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000					0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					0	89.00
90.00	09000	CLINIC	0.564979	0	264,478	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.210331	0	150,428	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	443	0	0	0	90.02
91.00	09100	EMERGENCY	1.098095	0	955,421	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	304,375	0	0	0	92.00
200.00		Subtotal (see instructions)		0	20,302,956	701	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	20,302,956	701		0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 1:38 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	624,177	0		50.00
53.00	05300	ANESTHESIOLOGY	199,243	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,427	0		54.00
54.01	05401	ONCOLOGY	462,446	0		54.01
56.00	05600	RADIOISOTOPE	125,709	0		56.00
57.00	05700	CT SCAN	153,869	0		57.00
58.00	05800	MRI	93,636	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	871,039	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	223,326	0		65.00
66.00	06600	PHYSICAL THERAPY	361,875	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	84,954	0		67.00
68.00	06800	SPEECH PATHOLOGY	20,288	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,470	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,709	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,404	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,380	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,016,142	267		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	632,812	0		76.00
76.01	03020	OP IV THERAPY/NURSING	34,632	0		76.01
76.02	03030	SLEEP STUDY	35,207	0		76.02
76.97	07697	CARDIAC REHABILITATION	72,691	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	149,425	0		90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	31,640	0		90.01
90.02	04050	TELEMEDICINE	155	0		90.02
91.00	09100	EMERGENCY	1,049,143	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	500,970	0		92.00
200.00		Subtotal (see instructions)	8,380,769	267		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,380,769	267		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1307

Period:

Worksheet D

Component CCN:14-Z307

From 05/01/2019

Part V

To 04/30/2020

Date/Time Prepared:

9/29/2020 1:38 pm

			Title XVIII	Swing Beds - SNF		Cost		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1.348223	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	0	0	0	0	54.00
54.01	05401	ONCOLOGY	1.202102	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.509447	0	0	0	0	56.00
57.00	05700	CT SCAN	0.055770	0	0	0	0	57.00
58.00	05800	MRI	0.162589	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.223442	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.564979	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.210331	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.098095	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:

Worksheet D

Component CCN: 14-Z307

From 05/01/2019
To 04/30/2020Part V
Date/Time Prepared:
9/29/2020 1:38 pm

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ONCOLOGY	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0		76.00
76.01	03020	OP IV THERAPY/NURSING	0	0		76.01
76.02	03030	SLEEP STUDY	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0		90.01
90.02	04050	TELEMEDICINE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 1:38 pm

			Title XIX		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1.348223	0	33,203	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	0	22,314	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	0	443,079	0	0	0	54.00
54.01	05401	ONCOLOGY	1.202102	0	81,020	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.509447	0	45,341	0	0	0	56.00
57.00	05700	CT SCAN	0.055770	0	982,227	0	0	0	57.00
58.00	05800	MRI	0.162589	0	134,392	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.223442	0	1,172,519	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	0	45,710	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	0	217,674	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	0	98,149	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	0	30,898	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	0	37,485	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	751	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	0	20,189	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	927	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	0	1,228,407	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	110,490	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	44,128	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	19,077	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	1.496789					0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					0	89.00
90.00	09000	CLINIC	0.564979	0	19,800	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.210331	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	76	0	0	0	90.02
91.00	09100	EMERGENCY	1.098095	0	601,737	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	73,962	0	0	0	92.00
200.00		Subtotal (see instructions)		0	5,463,555	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0			201.00
202.00		Net Charges (line 200 - line 201)		0	5,463,555	0		0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 1:38 pm

			Title XIX		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	44,765	0		50.00
53.00	05300	ANESTHESIOLOGY	12,661	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,739	0		54.00
54.01	05401	ONCOLOGY	97,394	0		54.01
56.00	05600	RADIOISOTOPE	23,099	0		56.00
57.00	05700	CT SCAN	54,779	0		57.00
58.00	05800	MRI	21,851	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	261,990	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	53,720	0		65.00
66.00	06600	PHYSICAL THERAPY	84,572	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	35,780	0		67.00
68.00	06800	SPEECH PATHOLOGY	29,545	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,270	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	683	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,644	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	515	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	467,319	0		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0		76.00
76.01	03020	OP IV THERAPY/NURSING	9,337	0		76.01
76.02	03030	SLEEP STUDY	9,992	0		76.02
76.97	07697	CARDIAC REHABILITATION	11,531	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	11,187	0		90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0		90.01
90.02	04050	TELEMEDICINE	27	0		90.02
91.00	09100	EMERGENCY	660,764	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	121,734	0		92.00
200.00		Subtotal (see instructions)	2,200,898	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,200,898	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/29/2020 1:38 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)	2,988	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,184	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)	770	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	823	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)	421	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	389	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)	171	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	569	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)	728	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)	393	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	161.69	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	164.92	20.00	
21.00	Total general inpatient routine service cost (see instructions)	5,206,682	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)	62,897	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)	28,201	25.00	
26.00	Total swing-bed cost (see instructions)	2,712,094	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,494,588	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)	2,494,588	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,106.91	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,198,832	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)	1,198,832	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1307

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

Worksheet D-1

Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					292,879	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,491,711	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)					1,533,830	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					828,016	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,361,846	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)					414	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,106.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					872,265	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307		Period: From 05/01/2019 To 04/30/2020		Worksheet D-1 Date/Time Prepared: 9/29/2020 1:38 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	670,858	5,206,682	0.128846	872,265	112,388	90.00
91.00	Nursing School cost	0	5,206,682	0.000000	872,265	0	91.00
92.00	Allied health cost	0	5,206,682	0.000000	872,265	0	92.00
93.00	All other Medical Education	0	5,206,682	0.000000	872,265	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/29/2020 1:38 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		640,963		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.348223	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	1,052	597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	86,981	35,088	54.00
54.01	05401	ONCOLOGY	1.202102	16	19	54.01
56.00	05600	RADIOISOTOPE	0.509447	18,762	9,558	56.00
57.00	05700	CT SCAN	0.055770	153,852	8,580	57.00
58.00	05800	MRI	0.162589	16,701	2,715	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.223442	253,270	56,591	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	64,900	76,272	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	19,984	7,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	16,805	6,126	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	4,042	3,865	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	4,594	278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	55,502	18,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	176,401	67,108	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.564979	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.210331	0	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	0	90.02
91.00	09100	EMERGENCY	1.098095	49	54	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		872,911	292,879	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)		872,911		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3
			Component CCN: 14-Z307		Date/Time Prepared: 9/29/2020 1:38 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
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.348223	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	41,352	54.00
54.01	05401	ONCOLOGY	1.202102	0	54.01
56.00	05600	RADIOISOTOPE	0.509447	2,287	56.00
57.00	05700	CT SCAN	0.055770	64,752	57.00
58.00	05800	MRI	0.162589	3,570	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.223442	188,213	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	50,473	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	283,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	211,827	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	26,419	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	3,308	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	75,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	326,615	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.564979	4,168	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.210331	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	90.02
91.00	09100	EMERGENCY	1.098095	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,282,136	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)		1,282,136	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/29/2020 1:38 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		37,926		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.348223	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.567424	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.403402	3,590	1,448	54.00
54.01	05401	ONCOLOGY	1.202102	0	0	54.01
56.00	05600	RADIOISOTOPE	0.509447	0	0	56.00
57.00	05700	CT SCAN	0.055770	12,444	694	57.00
58.00	05800	MRI	0.162589	5,991	974	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.223442	9,671	2,161	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.175226	160	188	65.00
66.00	06600	PHYSICAL THERAPY	0.388528	832	323	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364547	892	325	67.00
68.00	06800	SPEECH PATHOLOGY	0.956205	421	403	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060562	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.909293	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.329071	1,066	351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.555835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380427	11,898	4,526	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.720863	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.084501	0	0	76.01
76.02	03030	SLEEP STUDY	0.226427	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.604456	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.496789	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.564979	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.210331	0	0	90.01
90.02	04050	TELEMEDICINE	0.350586	0	0	90.02
91.00	09100	EMERGENCY	1.098095	12,355	13,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.645898	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		59,320	24,960	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)		59,320		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/29/2020 1:38 pm
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,381,036	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)		8,381,036	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,464,846	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)		37,688	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,265,969	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)		5,161,189	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)		5,161,189	30.00
31.00	Primary payer payments		1,160	31.00
32.00	Subtotal (line 30 minus line 31)		5,160,029	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)		381,156	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		247,751	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		125,601	36.00
37.00	Subtotal (see instructions)		5,407,780	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,407,780	40.00
40.01	Sequestration adjustment (see instructions)		108,156	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		4,838,878	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)		460,746	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: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/29/2020 1:38 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		1,205,290		4,831,823	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	04/08/2020	126,375	11/13/2019	7,271	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	11/13/2019	27,770	04/08/2020	216	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)		98,605		7,055	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)		1,303,895		4,838,878	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		40,903		460,746	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,344,798		5,299,624	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307

Period:

Worksheet E-1

Component CCN: 14-Z307

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 1:38 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		2,477,857		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	04/08/2020	210,495		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	11/13/2019	12,533		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)		197,962		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,675,819		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		97,519		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,773,338		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
9/29/2020 1:38 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:14-1307 Component CCN:14-Z307	Period: From 05/01/2019 To 04/30/2020	Worksheet E-2 Date/Time Prepared: 9/29/2020 1:38 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)		2,385,464	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)		492,603	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		1,121	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,878,067	0	8.00
9.00	Primary payer payments (see instructions)			0	9.00
10.00	Subtotal (line 8 minus line 9)		2,878,067	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,878,067	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		48,130	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,829,937	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,829,937	0	19.00
19.01	Sequestration adjustment (see instructions)		56,599	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		2,675,819	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)		97,519	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: 14-1307	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part V Date/Time Prepared: 9/29/2020 1:38 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,491,711	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)		1,491,711	4.00
5.00	Primary payer payments		1,136	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,505,492	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)		1,505,492	19.00
20.00	Deductibles (exclude professional component)		170,281	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,335,211	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,335,211	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		56,973	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		37,032	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,359	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,372,243	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)		1,372,243	30.00
30.01	Sequestration adjustment (see instructions)		27,445	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		1,303,895	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)		40,903	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: 14-1307

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

Worksheet G

Date/Time Prepared:
9/29/2020 1:38 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	18,533,144	0	0	0	1.00
2.00	Temporary investments	106,990	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,793,277	0	0	0	4.00
5.00	Other receivable	311,434	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	305,070	0	0	0	7.00
8.00	Prepaid expenses	278,867	0	0	0	8.00
9.00	Other current assets	919,800	0	0	49,206	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,248,582	0	0	49,206	11.00
FIXED ASSETS						
12.00	Land	522,113	0	0	0	12.00
13.00	Land improvements	3,201,568	0	0	0	13.00
14.00	Accumulated depreciation	-898,732	0	0	0	14.00
15.00	Buildings	34,850,797	0	0	0	15.00
16.00	Accumulated depreciation	-8,245,928	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,070,558	0	0	0	23.00
24.00	Accumulated depreciation	-4,280,693	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,682,323	0	0	0	27.00
28.00	Accumulated depreciation	-1,665,722	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,236,284	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	5,779,338	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,779,338	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,264,204	0	0	49,206	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	363,058	0	0	0	37.00
38.00	Salaries, wages, and fees payable	807,437	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	437,609	0	0	0	40.00
41.00	Deferred income	282,550	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	10,234,112	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,124,766	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	24,904,221	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,904,221	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,028,987	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,235,217	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	49,206	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,235,217	0	0	49,206	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,264,204	0	0	49,206	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1307

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

Worksheet G-1

Date/Time Prepared:
9/29/2020 1:38 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		21,019,764		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,219,253				2.00
3.00	Total (sum of line 1 and line 2)		22,239,017		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,239,017		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER	3,800		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)		3,800		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,235,217		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		45,406			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		45,406			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER		3,800				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		3,800			10.00
11.00	Subtotal (line 3 plus line 10)	0		49,206			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER		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		49,206			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/29/2020 1:38 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	854,583		854,583	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	562,883		562,883	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,417,466		1,417,466	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,417,466		1,417,466	17.00
18.00	Ancillary services	2,784,889	35,989,887	38,774,776	18.00
19.00	Outpatient services	72,501	3,551,492	3,623,993	19.00
20.00	RURAL HEALTH CLINIC	0	3,005,840	3,005,840	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	70,706	2,217,382	2,288,088	27.00
27.01	340 GROSS UP	0	0	0	27.01
27.02	RHC CHRONIC & TRANSITIONAL CARE	0	27,455	27,455	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,345,562	44,792,056	49,137,618	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,321,699		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)		28,321,699		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1307

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

Worksheet G-3

Date/Time Prepared:
9/29/2020 1:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,137,618	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,090,769	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,046,849	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,321,699	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,274,850	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	34,501	6.00
7.00	Income from investments	236,513	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	64,292	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	73,393	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	6,776	17.00
18.00	Revenue from sale of medical records and abstracts	3,481	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	35,765	22.00
23.00	Governmental appropriations	311,486	23.00
24.00	CONTRACT SERVICES	54,808	24.00
24.01	MISC OPERATING REVENUE	252,355	24.01
24.02	MISC NON-OPERATING REVENUE	2,735	24.02
24.03	340B DISCOUNT	1,417,998	24.03
25.00	Total other income (sum of lines 6-24)	2,494,103	25.00
26.00	Total (line 5 plus line 25)	1,219,253	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,219,253	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period:

Worksheet M-1

Component CCN: 14-3412

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/29/2020 1:38 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	919,880	14,326	934,206	-119,620	814,586
2.00	Physician Assistant	285,429	0	285,429	-676	284,753
3.00	Nurse Practitioner	135,291	0	135,291	-47	135,244
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	420,507	0	420,507	-47,028	373,479
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	16,048	16,048	-2,283	13,765
10.00	Subtotal (sum of lines 1 through 9)	1,761,107	30,374	1,791,481	-169,654	1,621,827
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	175,760	175,760	0	175,760
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	40,263	40,263	0	40,263
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	216,023	216,023	0	216,023
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,761,107	246,397	2,007,504	-169,654	1,837,850
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	1,580	1,580
25.02	Chronic Care Management	0	0	0	10,398	10,398
26.00	All other nonreimbursable costs	0	0	0	34,826	34,826
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	46,804	46,804
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	571,961	31,654	603,615	0	603,615
31.00	Total Facility Overhead (sum of lines 29 and 30)	571,961	31,654	603,615	0	603,615
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,333,068	278,051	2,611,119	-122,850	2,488,269

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period:

Worksheet M-1

Component CCN: 14-3412

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/29/2020 1:38 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	814,586	1.00
2.00	Physician Assistant	0	284,753	2.00
3.00	Nurse Practitioner	0	135,244	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	373,479	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	13,765	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,621,827	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	175,760	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	40,263	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216,023	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,837,850	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	1,580	25.01
25.02	Chronic Care Management	0	10,398	25.02
26.00	All other nonreimbursable costs	0	34,826	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	46,804	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-1,030	602,585	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,030	602,585	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,030	2,487,239	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1307

Period:

Worksheet M-2

Component CCN: 14-3412

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/29/2020 1:38 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	1.92	9,492	4,200	8,064		1.00
2.00	Physician Assistant	1.72	4,883	2,100	3,612		2.00
3.00	Nurse Practitioner	1.25	2,876	2,100	2,625		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.89	17,251		14,301	17,251	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)	4.89	17,251			17,251	8.00
9.00	Physician Services Under Agreements		72			72	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,837,850	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					46,804	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,884,654	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.975166	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					602,585	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,052,964	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,655,549	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,655,549	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,589,601	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,427,451	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2019 To 04/30/2020	Worksheet M-3 Date/Time Prepared: 9/29/2020 1:38 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)			4,427,451	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			164,334	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,263,117	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,251	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			72	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			17,323	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			246.10	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			246.10	246.10	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			4,144	2,072	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			1,019,838	509,919	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	1,529,757	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,025,089	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				41,050	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				61,259	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.)				1,109,700	16.04
16.05	Total program cost (see instructions)			0	1,170,959	16.05
17.00	Primary payer amounts				20	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				81,373	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				180,533	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,170,939	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				82,610	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,253,549	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)				1,253,549	26.00
26.01	Sequestration adjustment (see instructions)				25,071	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,122,305	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)				106,173	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: 14-1307 Component CCN: 14-3412	Period: From 05/01/2019 To 04/30/2020	Worksheet M-4 Date/Time Prepared: 9/29/2020 1:38 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)		1,621,827	1,621,827	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000568	0.002009	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		921	3,258	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		37,503	26,534	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		38,424	29,792	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,837,850	1,837,850	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,589,601	2,589,601	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.020907	0.016210	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		54,141	41,977	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		92,565	71,769	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		245	866	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		377.82	82.87	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		116	468	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		43,827	38,783	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)			164,334	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)			82,610	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2019 To 04/30/2020	Worksheet M-5 Date/Time Prepared: 9/29/2020 1:38 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		985,800	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		04/08/2020	145,651	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		11/13/2019	9,146	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)		136,505	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,122,305	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		106,173	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,228,478	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.	06101	8.00