

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

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

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

Provider CCN: 14-1311

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

Worksheet S
Parts I-III
Date/Time Prepared:
2/1/2021 8:41 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/1/2021	Time: 8:41 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAIRFIELD MEMORIAL HOSPITAL (14-1311) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	288,620	96,267	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	493		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		797,645		0	10.00
200.00	Total	0	288,620	894,404	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1311		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 8:41 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 303 NW 11TH ST			PO Box:				1.00	
2.00	City: FAIRFIELD			State: IL		Zip Code: 62837		County: WAYNE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		FAIRFIELD MEMORIAL HOSPITAL	141311	99914	1	04/01/2001	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF		FAIRFIELD MEMORIAL HOSPITAL	145552	99914		03/26/1985	N	P
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA		FAIRFIELD MEMORIAL HOSPITAL HHA	147612	99914		05/01/1995	N	P
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		FAIRFIELD RHC	148500	99914		03/13/2009	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1311

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From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/1/2021 8:41 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
				Urban/Rural S	Date of Geogr		
				1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
				Beginning:	Ending:		
				1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
				Y/N	Y/N		
				1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
				V	XVIII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							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: 14-1311		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 8:41 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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.	N		N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	384,344		0		118.01	
				1.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
				Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 8:41 am
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		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
			1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00
		Part A	Part B	Title V
		1.00	2.00	3.00
				Title XIX
				4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)				
155.00	Hospital	N	N	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
				1.00
Multicampus				
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00
		Name	County	State
		0	1.00	2.00
				Zip Code
				3.00
				CBSA
				4.00
				FTE/Campus
				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: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 8:41 am
			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: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 2/1/2021 8:41 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/04/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 2/1/2021 8:41 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.		Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.	TEDI	ZOTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD CPAS AND ADVISORS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.236.5179	TZOTZ@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
2/1/2021 8:41 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGING CONSULTANT	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: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 8:41 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	32,184.00	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)		21	7,686	32,184.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	3,936.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	36,120.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	30	10,980		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		55				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: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 8:41 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	909	35	1,341		1.00
2.00	HMO and other (see instructions)	0	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	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	909	35	1,341		7.00
8.00	INTENSIVE CARE UNIT	57	0	164		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)	966	35	1,505	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	966	0	7,972	0.00	19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	3,003	7	3,862	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	7,392	3,508	25,642	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		89	766		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: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 8:41 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	333	11	483	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	333	11	483	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	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

Health Financial Systems		FAIRFIELD MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-1311 Component CCN: 14-7612	Period: From 07/01/2019 To 06/30/2020	Worksheet S-4 Date/Time Prepared: 2/1/2021 8:41 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	WAYNE				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	159.00	5.00	60.00	224.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.71	0.00	1.71	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.29	0.00	3.29	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.49	0.00	0.49	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.13	0.00	0.13	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			14999			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,141	708	34	2	1,885	21.00
22.00	Skilled Nursing Visit Charges	138,776	85,650	4,142	244	228,812	22.00
23.00	Physical Therapy Visits	688	133	36	2	859	23.00
24.00	Physical Therapy Visit Charges	83,654	16,118	3,538	244	103,554	24.00
25.00	Occupational Therapy Visits	169	47	8	2	226	25.00
26.00	Occupational Therapy Visit Charges	20,582	5,728	976	244	27,530	26.00
27.00	Speech Pathology Visits	21	11	1	0	33	27.00
28.00	Speech Pathology Visit Charges	2,616	1,397	127	0	4,140	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,019	899	79	6	3,003	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	245,628	108,893	8,783	732	364,036	35.00
36.00	Total Number of Episodes (standard/non outlier)	179		32	1	212	36.00
37.00	Total Number of Outlier Episodes		34		0	34	37.00
38.00	Total Non-Routine Medical Supply Charges	53,630	22,968	4,472	13	81,083	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1311 Component CCN: 14-8500		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 2/1/2021 8:41 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				303 NW 11TH STREET		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				FAIRFIELD IL 62837		2.00		
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:30		05:00		08:30
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y		3		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				FAIRFIELD RHC		148500		14.00
14.01					HORIZON HEALTHCARE		148591		14.01
14.02					HORIZON HEALTHCARE GRAYVILLE		148602		14.02
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				WAYNE				2.00

MCRIF32 - 16.7.171.0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 2/1/2021 8:41 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.364075 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,924,388		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	16,196,725		6.00
7.00	Medicaid cost (line 1 times line 6)	5,896,823		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)	3,972,435		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,972,435		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)	235,042	320,439	555,481 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	85,573	320,439	406,012 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)	85,573	320,439	406,012 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)	4,501,498		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	860,567		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,323,948		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,177,550		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,620,248		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,026,260		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,998,695		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1311

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

Worksheet A

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,322,897	1,322,897	281,922	1,604,819	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		549,759	549,759	0	549,759	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,963,837	3,963,837	0	3,963,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,706,927	3,204,473	4,911,400	-129,351	4,782,049	5.00
6.00	00600	MAINTENANCE & REPAIRS	401,801	275,127	676,928	0	676,928	6.00
7.00	00700	OPERATION OF PLANT	0	658,281	658,281	0	658,281	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	397,695	397,695	0	397,695	8.00
9.00	00900	HOUSEKEEPING	355,981	126,282	482,263	0	482,263	9.00
10.00	01000	DIETARY	379,527	351,754	731,281	-493,070	238,211	10.00
11.00	01100	CAFETERIA	0	0	0	493,070	493,070	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	257,455	34,637	292,092	0	292,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,520	639,507	697,027	-26,881	670,146	14.00
15.00	01500	PHARMACY	241,784	1,129,836	1,371,620	0	1,371,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	308,748	182,689	491,437	0	491,437	16.00
17.00	01700	SOCIAL SERVICE	64,914	4,591	69,505	0	69,505	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,268,351	279,256	1,547,607	0	1,547,607	30.00
31.00	03100	INTENSIVE CARE UNIT	131,399	4,394	135,793	0	135,793	31.00
44.00	04400	SKILLED NURSING FACILITY	821,600	92,802	914,402	0	914,402	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	704,002	280,313	984,315	0	984,315	50.00
53.00	05300	ANESTHESIOLOGY	559,530	72,423	631,953	0	631,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,074	958,599	1,551,673	0	1,551,673	54.00
60.00	06000	LABORATORY	875,227	1,386,984	2,262,211	0	2,262,211	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	210,555	129,717	340,272	-61,981	278,291	65.00
66.00	06600	PHYSICAL THERAPY	561,328	8,542	569,870	-47,314	522,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	126,330	0	126,330	-12,466	113,864	67.00
68.00	06800	SPEECH PATHOLOGY	113,513	32	113,545	-2,593	110,952	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	61,981	61,981	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,881	26,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	207,961	113,875	321,836	0	321,836	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,411,816	536,719	3,948,535	129,351	4,077,886	88.00
90.00	09000	CLINIC	392,153	45,047	437,200	0	437,200	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	109,645	138,416	248,061	0	248,061	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	940,027	2,103,746	3,043,773	0	3,043,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	347,801	81,773	429,574	62,373	491,947	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		281,922	281,922	-281,922	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,148,969	19,355,925	34,504,894	0	34,504,894	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	60	60	0	60	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,148,969	19,355,985	34,504,954	0	34,504,954	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1311

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

Worksheet A

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-307,326	1,297,493	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	549,759	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,963,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,206,256	3,575,793	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	676,928	6.00
7.00	00700	OPERATION OF PLANT	0	658,281	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	397,695	8.00
9.00	00900	HOUSEKEEPING	0	482,263	9.00
10.00	01000	DIETARY	0	238,211	10.00
11.00	01100	CAFETERIA	-172,814	320,256	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	292,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	670,146	14.00
15.00	01500	PHARMACY	0	1,371,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,176	478,261	16.00
17.00	01700	SOCIAL SERVICE	0	69,505	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-149,739	1,397,868	30.00
31.00	03100	INTENSIVE CARE UNIT	0	135,793	31.00
44.00	04400	SKILLED NURSING FACILITY	0	914,402	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	984,315	50.00
53.00	05300	ANESTHESIOLOGY	-559,530	72,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,551,673	54.00
60.00	06000	LABORATORY	0	2,262,211	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	278,291	65.00
66.00	06600	PHYSICAL THERAPY	0	522,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,864	67.00
68.00	06800	SPEECH PATHOLOGY	0	110,952	68.00
69.00	06900	ELECTROCARDIOLOGY	-27,723	34,258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	321,836	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-82,941	3,994,945	88.00
90.00	09000	CLINIC	0	437,200	90.00
90.01	09001	WOUND CARE	0	0	90.01
90.02	09002	CLINIC	0	248,061	90.02
90.03	09003	URGENT CARE	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	90.04
91.00	09100	EMERGENCY	-1,431,984	1,611,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	491,947	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,951,489	30,553,405	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	VENDING MACHINE	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	60	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,951,489	30,553,465	200.00

RECLASSIFICATIONS

Provider CCN: 14-1311

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

Worksheet A-6

Date/Time Prepared:
2/1/2021 8:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - TO RECLASS CAFETERIA					1.00
	CAFETERIA	11.00	255,898	237,172		
	0		255,898	237,172		
1.00	B - TO RECLASS EKG					1.00
	ELECTROCARDIOLOGY	69.00	34,258	27,723		
	0		34,258	27,723		
1.00	C - TO RECLASS INTEREST					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	281,922		
	0		0	281,922		
1.00	D - TO RECLASS IMPLANTABLE DEVICES					1.00
	IMPL. DEV. CHARGED TO	72.00	0	26,881		
	PATIENTS		0	26,881		
1.00	E - PT, OT, AND ST OTHER EXPENSES					1.00
	OCCUPATIONAL THERAPY	67.00	0	1,555		
	SPEECH PATHOLOGY	68.00	0	955		
2.00	TOTALS		0	2,510	2.00	
F - HHA THERAPISTS						
1.00	HOME HEALTH AGENCY	101.00	62,373	0	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		62,373	0		
H - RHC RECRUITING EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	129,351	1.00	
	TOTALS		0	129,351		
500.00	Grand Total: Increases		352,529	705,559	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1311

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

Worksheet A-6

Date/Time Prepared:
2/1/2021 8:41 am

		Decreases				wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - TO RECLASS CAFETERIA							
1.00	DIETARY		10.00	255,898	237,172	0	1.00
	0			255,898	237,172		
B - TO RECLASS EKG							
1.00	RESPIRATORY THERAPY		65.00	34,258	27,723	0	1.00
	0			34,258	27,723		
C - TO RECLASS INTEREST							
1.00	INTEREST EXPENSE		113.00	0	281,922	11	1.00
	0			0	281,922		
D - TO RECLASS IMPLANTABLE DEVICES							
1.00	CENTRAL SERVICES & SUPPLY		14.00	0	26,881	0	1.00
	0			0	26,881		
E - PT, OT, AND ST OTHER EXPENSES							
1.00	PHYSICAL THERAPY		66.00	0	2,510	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	2,510		
F - HHA THERAPISTS							
1.00	PHYSICAL THERAPY		66.00	44,804	0	0	1.00
2.00	OCCUPATIONAL THERAPY		67.00	14,021	0	0	2.00
3.00	SPEECH PATHOLOGY		68.00	3,548	0	0	3.00
	TOTALS			62,373	0		
H - RHC RECRUITING EXPENSES							
1.00	ADMINISTRATIVE & GENERAL		5.00	0	129,351	0	1.00
	TOTALS			0	129,351		
500.00	Grand Total: Decreases			352,529	705,559		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
2/1/2021 8:41 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	449,428	0	0	0	0	1.00
2.00	Land Improvements	657,953	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,910,829	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,982,406	181,916	0	181,916	0	5.00
6.00	Movable Equipment	14,936,696	894,953	0	894,953	0	6.00
7.00	HIT designated Assets	1,435,870	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,373,182	1,076,869	0	1,076,869	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,373,182	1,076,869	0	1,076,869	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	449,428	0				1.00
2.00	Land Improvements	657,953	0				2.00
3.00	Buildings and Fixtures	19,910,829	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,164,322	0				5.00
6.00	Movable Equipment	15,831,649	0				6.00
7.00	HIT designated Assets	1,435,870	0				7.00
8.00	Subtotal (sum of lines 1-7)	40,450,051	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40,450,051	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,322,897	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	549,759	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,872,656	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,322,897				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	549,759				2.00
3.00	Total (sum of lines 1-2)	0	1,872,656				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,182,532	0	23,182,532	0.573115	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,267,519	0	17,267,519	0.426885	0	2.00
3.00	Total (sum of lines 1-2)	40,450,051	0	40,450,051	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	1,068,651	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	549,759	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,618,410	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	228,842	0	0	0	1,297,493	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	549,759	2.00
3.00	Total (sum of lines 1-2)	228,842	0	0	0	1,847,252	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1311

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

Worksheet A-8

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-53,080	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,941	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,390	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	-2,168,976			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-498	ADMINISTRATIVE & GENERAL	5.00	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	-172,814	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,176	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1311

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

Worksheet A-8

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				1.00	2.00		
				3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A		0 CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	VERIZON RENTAL	B	-97,285	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	RINARD & WEBER CLINIC	A	-6,961	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	RECRUITING	A	-48,899	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-252,407	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER REVENUE	B	-9,093	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	WAYFAIR RENTAL	B	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	PROVIDER TAX	A	-845,579	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08	NONALLOWABLE ALCOHOL	A	-916	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT RELATED TAX EXPENSE	A	13,582	ADMINISTRATIVE & GENERAL	5.00	0	33.09
34.00	HOSPITALIST IN RHC	A	-82,941	RURAL HEALTH CLINIC	88.00	0	34.00
43.00	LOBBYING PORTION OF DUES	A	-12,418	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	DONATIONS	A	-35,697	ADMINISTRATIVE & GENERAL	5.00	0	43.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,951,489				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1311

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

Worksheet A-8-1

Date/Time Prepared:
2/1/2021 8:41 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	MRI	267,725	267,725	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			267,725	267,725	5.00

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

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

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

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

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

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				100.00

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

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

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

Provider CCN: 14-1311

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

Worksheet A-8-1

Date/Time Prepared:

2/1/2021 8:41 am

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

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

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

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

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

6.00	MRI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1311

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

Worksheet A-8-2

Date/Time Prepared:
2/1/2021 8:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	128,098	128,098	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	559,530	559,530	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	21,641	21,641	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	27,723	27,723	0	0	0	4.00
5.00	91.00	EMERGENCY	1,918,778	1,431,984	486,794	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,655,770	2,168,976	486,794		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	128,098		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	559,530		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	21,641		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	27,723		4.00
5.00	91.00	EMERGENCY	0	0	0	1,431,984		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,168,976		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,297,493	1,297,493			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	549,759		549,759		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,963,837	0	0	3,963,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,575,793	222,044	94,082	467,867	5.00
6.00	00600	MAINTENANCE & REPAIRS	676,928	31,962	13,543	110,133	6.00
7.00	00700	OPERATION OF PLANT	658,281	20,891	8,852	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	397,695	14,435	6,116	0	8.00
9.00	00900	HOUSEKEEPING	482,263	1,998	846	97,574	9.00
10.00	01000	DIETARY	238,211	1,478	626	33,887	10.00
11.00	01100	CAFETERIA	320,256	43,441	18,406	70,141	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	292,092	1,445	612	70,568	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	670,146	0	0	15,766	14.00
15.00	01500	PHARMACY	1,371,620	0	0	66,273	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478,261	16,625	7,044	84,628	16.00
17.00	01700	SOCIAL SERVICE	69,505	1,806	765	17,793	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,397,868	164,767	69,813	312,542	30.00
31.00	03100	INTENSIVE CARE UNIT	135,793	15,044	6,374	36,016	31.00
44.00	04400	SKILLED NURSING FACILITY	914,402	96,531	40,901	225,200	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	984,315	72,480	30,710	192,966	50.00
53.00	05300	ANESTHESIOLOGY	72,423	790	335	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,551,673	51,668	21,892	162,561	54.00
60.00	06000	LABORATORY	2,262,211	25,597	10,846	239,899	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	278,291	19,006	8,053	48,323	65.00
66.00	06600	PHYSICAL THERAPY	522,556	29,796	12,625	141,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,864	7,686	3,257	30,784	67.00
68.00	06800	SPEECH PATHOLOGY	110,952	4,718	1,999	30,141	68.00
69.00	06900	ELECTROCARDIOLOGY	34,258	0	0	9,390	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,044	8,493	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,881	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,789	13,045	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	321,836	19,582	8,297	57,002	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,994,945	322,748	136,752	935,173	88.00
90.00	09000	CLINIC	437,200	0	0	107,489	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	248,061	12,246	5,189	30,054	90.02
90.03	09003	URGENT CARE	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,611,789	26,207	11,104	257,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	491,947	21,669	9,182	112,428	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,553,405	1,297,493	549,759	3,963,837	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	VENDING MACHINE	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	60	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,553,465	1,297,493	549,759	3,963,837	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,359,786					5.00
6.00	00600	MAINTENANCE & REPAIRS	138,576	971,142				6.00
7.00	00700	OPERATION OF PLANT	114,517	19,442	821,983			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,615	13,434	11,603	512,898		8.00
9.00	00900	HOUSEKEEPING	96,984	1,859	1,606	106,263	789,393	9.00
10.00	01000	DIETARY	45,639	1,376	1,188	621	1,160	10.00
11.00	01100	CAFETERIA	75,273	40,429	34,918	0	34,082	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	60,705	1,344	1,161	0	1,133	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,166	0	0	0	0	14.00
15.00	01500	PHARMACY	239,329	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,629	15,472	13,363	0	13,043	16.00
17.00	01700	SOCIAL SERVICE	14,958	1,681	1,452	0	1,417	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	323,732	153,344	132,443	83,550	129,269	30.00
31.00	03100	INTENSIVE CARE UNIT	32,161	14,001	12,093	371	11,803	31.00
44.00	04400	SKILLED NURSING FACILITY	212,555	89,838	77,593	94,558	75,734	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	213,127	67,455	58,261	71,115	56,865	50.00
53.00	05300	ANESTHESIOLOGY	12,242	735	635	0	620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,568	48,086	41,532	37,710	40,537	54.00
60.00	06000	LABORATORY	422,527	23,822	20,575	3,858	20,082	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	58,867	17,688	15,277	7,716	14,911	65.00
66.00	06600	PHYSICAL THERAPY	117,602	27,730	23,950	8,022	23,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,897	7,153	6,178	2,071	6,030	67.00
68.00	06800	SPEECH PATHOLOGY	24,602	4,391	3,792	1,264	3,701	68.00
69.00	06900	ELECTROCARDIOLOGY	7,265	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,750	18,655	16,112	0	15,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,474	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,296	28,654	24,749	0	24,156	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67,696	18,224	15,740	0	15,363	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	897,072	300,375	259,436	7,237	253,216	88.00
90.00	09000	CLINIC	90,660	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	49,193	11,397	9,843	0	9,607	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	317,369	24,390	21,065	88,542	20,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	105,730	20,167	17,418	0	17,001	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,359,776	971,142	821,983	512,898	789,393	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	10	0	0	0	0	192.00
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)	4,359,786	971,142	821,983	512,898	789,393	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	324,186					10.00
11.00	01100	CAFETERIA	0	636,946				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	13,910	0	442,970		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,329	0	0	806,407	14.00
15.00	01500	PHARMACY	0	11,169	0	15,112	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,767	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,415	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	80,406	76,386	0	103,420	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,259	7,310	0	9,899	0	31.00
44.00	04400	SKILLED NURSING FACILITY	237,521	68,230	0	92,367	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,060	0	35,296	0	50.00
53.00	05300	ANESTHESIOLOGY	0	20,713	0	28,054	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,078	0	0	0	54.00
60.00	06000	LABORATORY	0	70,227	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	11,879	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,294	0	38,295	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,178	0	7,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,994	0	5,429	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,301	0	3,122	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	772,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	33,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,098	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	130,501	0	0	0	88.00
90.00	09000	CLINIC	0	8,089	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	7,344	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	55,674	0	75,389	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	29,570	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	324,186	636,946	0	442,970	806,407	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	324,186	636,946	0	442,970	806,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,703,503					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	754,832				16.00
17.00	01700	SOCIAL SERVICE	0	0	114,792			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	43,540	28,554	0	3,099,634	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,208	0	0	289,332	31.00
44.00	04400	SKILLED NURSING FACILITY	0	12,907	13,290	0	2,251,627	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	110,097	0	0	1,918,747	50.00
53.00	05300	ANESTHESIOLOGY	0	332	0	0	136,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,121	0	0	2,471,426	54.00
60.00	06000	LABORATORY	0	141,115	0	0	3,240,759	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	33,099	0	0	513,110	65.00
66.00	06600	PHYSICAL THERAPY	0	17,580	0	0	991,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,533	0	0	219,648	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,783	0	0	197,766	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,470	0	0	66,806	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,820	0	0	899,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,879	0	0	67,131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,703,503	53,051	0	0	1,885,243	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10,149	0	0	546,987	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	45,715	0	0	7,283,170	88.00
90.00	09000	CLINIC	0	5,779	0	0	649,217	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	2,563	0	0	385,497	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	32,091	72,948	0	2,614,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	825,112	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,703,503	754,832	114,792	0	30,553,395	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	70	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,703,503	754,832	114,792	0	30,553,465	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE	0	90.01
90.02	09002	CLINIC	0	90.02
90.03	09003	URGENT CARE	0	90.03
90.04	09004	CISNE CLINIC	0	90.04
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.01	19001	VENDING MACHINE	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	222,044	94,082	316,126	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	31,962	13,543	45,505	0 6.00
7.00	00700	OPERATION OF PLANT	0	20,891	8,852	29,743	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,435	6,116	20,551	0 8.00
9.00	00900	HOUSEKEEPING	0	1,998	846	2,844	0 9.00
10.00	01000	DIETARY	0	1,478	626	2,104	0 10.00
11.00	01100	CAFETERIA	0	43,441	18,406	61,847	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	1,445	612	2,057	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,625	7,044	23,669	0 16.00
17.00	01700	SOCIAL SERVICE	0	1,806	765	2,571	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	164,767	69,813	234,580	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,044	6,374	21,418	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	96,531	40,901	137,432	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	72,480	30,710	103,190	0 50.00
53.00	05300	ANESTHESIOLOGY	0	790	335	1,125	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,668	21,892	73,560	0 54.00
60.00	06000	LABORATORY	0	25,597	10,846	36,443	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	19,006	8,053	27,059	0 65.00
66.00	06600	PHYSICAL THERAPY	0	29,796	12,625	42,421	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,686	3,257	10,943	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	4,718	1,999	6,717	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,044	8,493	28,537	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	30,789	13,045	43,834	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	19,582	8,297	27,879	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	322,748	136,752	459,500	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CARE	0	0	0	0	0 90.01
90.02	09002	CLINIC	0	12,246	5,189	17,435	0 90.02
90.03	09003	URGENT CARE	0	0	0	0	0 90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	26,207	11,104	37,311	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	21,669	9,182	30,851	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,297,493	549,759	1,847,252	0 118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	VENDING MACHINE	0	0	0	0	0 190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,297,493	549,759	1,847,252	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	316,126					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,048	55,553				6.00
7.00	00700	OPERATION OF PLANT	8,304	1,112	39,159			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,048	768	553	26,920		8.00
9.00	00900	HOUSEKEEPING	7,032	106	76	5,577	15,635	9.00
10.00	01000	DIETARY	3,309	79	57	33	23	10.00
11.00	01100	CAFETERIA	5,458	2,313	1,663	0	675	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,402	77	55	0	22	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,278	0	0	0	0	14.00
15.00	01500	PHARMACY	17,354	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,079	885	637	0	258	16.00
17.00	01700	SOCIAL SERVICE	1,085	96	69	0	28	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,474	8,772	6,310	4,385	2,560	30.00
31.00	03100	INTENSIVE CARE UNIT	2,332	801	576	19	234	31.00
44.00	04400	SKILLED NURSING FACILITY	15,413	5,139	3,697	4,963	1,500	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,454	3,859	2,776	3,733	1,126	50.00
53.00	05300	ANESTHESIOLOGY	888	42	30	0	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,577	2,751	1,979	1,979	803	54.00
60.00	06000	LABORATORY	30,638	1,363	980	203	398	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,268	1,012	728	405	295	65.00
66.00	06600	PHYSICAL THERAPY	8,527	1,586	1,141	421	463	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,878	409	294	109	119	67.00
68.00	06800	SPEECH PATHOLOGY	1,784	251	181	66	73	68.00
69.00	06900	ELECTROCARDIOLOGY	527	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344	1,067	768	0	311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	324	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	529	1,639	1,179	0	478	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,909	1,042	750	0	304	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	65,041	17,183	12,357	380	5,019	88.00
90.00	09000	CLINIC	6,574	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	3,567	652	469	0	190	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	23,013	1,395	1,004	4,647	407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,667	1,154	830	0	337	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	316,125	55,553	39,159	26,920	15,635	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	1	0	0	0	0	192.00
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)	316,126	55,553	39,159	26,920	15,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,605					10.00
11.00	01100	CAFETERIA	0	71,956				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,571	0	8,184		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	715	0	0	8,993	14.00
15.00	01500	PHARMACY	0	1,262	0	279	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,250	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	612	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	1,390	8,629	0	1,910	0	30.00
31.00	03100	INTENSIVE CARE UNIT	108	826	0	183	0	31.00
44.00	04400	SKILLED NURSING FACILITY	4,107	7,708	0	1,707	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,944	0	652	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,340	0	518	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,076	0	0	0	54.00
60.00	06000	LABORATORY	0	7,934	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,342	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,196	0	708	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	585	0	130	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	451	0	100	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	260	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,480	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	14,742	0	0	0	88.00
90.00	09000	CLINIC	0	914	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	830	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	6,289	0	1,393	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	546	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,605	71,956	0	8,184	8,993	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	5,605	71,956	0	8,184	8,993	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	18,895					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,778				16.00
17.00	01700	SOCIAL SERVICE	0	0	4,461			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,064	1,110		295,184	30.00
31.00	03100	INTENSIVE CARE UNIT	0	105	0		26,602	31.00
44.00	04400	SKILLED NURSING FACILITY	0	612	516		182,794	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,219	0		138,953	50.00
53.00	05300	ANESTHESIOLOGY	0	16	0		4,971	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,629	0		115,354	54.00
60.00	06000	LABORATORY	0	6,689	0		84,648	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,569	0		36,678	65.00
66.00	06600	PHYSICAL THERAPY	0	833	0		59,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	215	0		14,682	67.00
68.00	06800	SPEECH PATHOLOGY	0	132	0		9,755	68.00
69.00	06900	ELECTROCARDIOLOGY	0	496	0		1,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,030	0		41,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89	0		791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,895	2,515	0		69,069	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	481	0		36,845	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,167	0		576,389	88.00
90.00	09000	CLINIC	0	274	0		7,762	90.00
90.01	09001	WOUND CARE	0	0	0		0	90.01
90.02	09002	CLINIC	0	122	0		23,265	90.02
90.03	09003	URGENT CARE	0	0	0		0	90.03
90.04	09004	CISNE CLINIC	0	0	0		0	90.04
91.00	09100	EMERGENCY	0	1,521	2,835		79,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0		0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0		41,385	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,895	35,778	4,461	0	1,847,251	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0		0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		1	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,895	35,778	4,461	0	1,847,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE	0	90.01
90.02	09002	CLINIC	0	90.02
90.03	09003	URGENT CARE	0	90.03
90.04	09004	CISNE CLINIC	0	90.04
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.01	19001	VENDING MACHINE	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1311

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

Worksheet B-1

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	114,963					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		114,963				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	14,461,341			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,674	19,674	1,706,927	-4,359,786	26,193,679	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,832	2,832	401,801	0	832,566	6.00
7.00	00700	OPERATION OF PLANT	1,851	1,851	0	0	688,024	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	418,246	8.00
9.00	00900	HOUSEKEEPING	177	177	355,981	0	582,681	9.00
10.00	01000	DIETARY	131	131	123,629	0	274,202	10.00
11.00	01100	CAFETERIA	3,849	3,849	255,898	0	452,244	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128	128	257,455	0	364,717	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	57,520	0	685,912	14.00
15.00	01500	PHARMACY	0	0	241,784	0	1,437,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	308,748	0	586,558	16.00
17.00	01700	SOCIAL SERVICE	160	160	64,914	0	89,869	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,599	14,599	1,140,253	0	1,944,990	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	131,399	0	193,227	31.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	821,600	0	1,277,034	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,422	6,422	704,002	0	1,280,471	50.00
53.00	05300	ANESTHESIOLOGY	70	70	0	0	73,548	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	593,074	0	1,787,794	54.00
60.00	06000	LABORATORY	2,268	2,268	875,227	0	2,538,553	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	176,297	0	353,673	65.00
66.00	06600	PHYSICAL THERAPY	2,640	2,640	516,524	0	706,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	681	681	112,309	0	155,591	67.00
68.00	06800	SPEECH PATHOLOGY	418	418	109,965	0	147,810	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	34,258	0	43,648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,776	1,776	0	0	28,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	26,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	0	0	43,834	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	207,961	0	406,717	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	28,597	28,597	3,411,816	0	5,389,618	88.00
90.00	09000	CLINIC	0	0	392,153	0	544,689	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,085	1,085	109,645	0	295,550	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,322	2,322	940,027	0	1,906,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	410,174	0	635,226	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,963	114,963	14,461,341	-4,359,786	26,193,619	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	60	192.00
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)	1,297,493	549,759	3,963,837		4,359,786	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.286179	4.782052	0.274099		0.166444	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		316,126	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.012069	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: 14-1311

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	92,457					6.00
7.00	00700	OPERATION OF PLANT	1,851	90,606				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	47,060			8.00
9.00	00900	HOUSEKEEPING	177	177	9,750	89,150		9.00
10.00	01000	DIETARY	131	131	57	131	35,686	10.00
11.00	01100	CAFETERIA	3,849	3,849	0	3,849	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	128	128	0	128	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	0	1,473	0	16.00
17.00	01700	SOCIAL SERVICE	160	160	0	160	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	14,599	14,599	7,666	14,599	8,851	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	34	1,333	689	31.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	8,676	8,553	26,146	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,422	6,422	6,525	6,422	0	50.00
53.00	05300	ANESTHESIOLOGY	70	70	0	70	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	3,460	4,578	0	54.00
60.00	06000	LABORATORY	2,268	2,268	354	2,268	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	708	1,684	0	65.00
66.00	06600	PHYSICAL THERAPY	2,640	2,640	736	2,640	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	681	681	190	681	0	67.00
68.00	06800	SPEECH PATHOLOGY	418	418	116	418	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,776	1,776	0	1,776	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	2,728	2,728	0	2,728	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	0	1,735	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	28,597	28,597	664	28,597	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	1,085	1,085	0	1,085	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,322	2,322	8,124	2,322	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	0	1,920	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,457	90,606	47,060	89,150	35,686	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	971,142	821,983	512,898	789,393	324,186	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.503715	9.072059	10.898810	8.854661	9.084403	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,553	39,159	26,920	15,635	5,605	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.600852	0.432190	0.572036	0.175379	0.157064	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: 14-1311

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FTES SERV ED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NRS ING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	18,820					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	411	0	201,052			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	187	0	0	4,939,132		14.00
15.00	01500	PHARMACY	330	0	6,859	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	850	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	160	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	2,257	0	46,939	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	216	0	4,493	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	2,016	0	41,923	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	770	0	16,020	0	0	50.00
53.00	05300	ANESTHESIOLOGY	612	0	12,733	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,066	0	0	0	0	54.00
60.00	06000	LABORATORY	2,075	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	351	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	836	0	17,381	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	153	0	3,185	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	118	0	2,464	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	68	0	1,417	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,731,518	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	207,614	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	387	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,856	0	0	0	0	88.00
90.00	09000	CLINIC	239	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	217	0	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,645	0	34,217	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	13,421	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,820	0	201,052	4,939,132	100	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
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)	636,946	0	442,970	806,407	1,703,503	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.844102	0.000000	2.203261	0.163269	17,035.030000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,956	0	8,184	8,993	18,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.823379	0.000000	0.040706	0.001821	188.950000	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: 14-1311

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

Worksheet B-1

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (ASSIGNED TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,403,764			16.00
17.00	01700	SOCIAL SERVICE	0	10,175		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,811,003	2,531	0	30.00
31.00	03100	INTENSIVE CARE UNIT	243,960	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	1,426,204	1,178	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,165,422	0	0	50.00
53.00	05300	ANESTHESIOLOGY	36,708	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,120,798	0	0	54.00
60.00	06000	LABORATORY	15,592,826	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,657,372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,942,572	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	500,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	307,517	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,156,925	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,731,518	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	207,614	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,861,941	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,121,439	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,051,398	0	0	88.00
90.00	09000	CLINIC	638,552	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	90.01
90.02	09002	CLINIC	283,235	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	90.04
91.00	09100	EMERGENCY	3,545,918	6,466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,403,764	10,175	0	118.00
NONREIMBURSABLE COST CENTERS						
190.01	19001	VENDING MACHINE	0	0	0	190.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
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)	754,832	114,792	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009050	11.281769	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,778	4,461	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000429	0.438428	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
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			Title XVIII		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,099,634		3,099,634	0	3,099,634
31.00	03100	INTENSIVE CARE UNIT	289,332		289,332	0	289,332
44.00	04400	SKILLED NURSING FACILITY	2,251,627		2,251,627	0	2,251,627
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,918,747		1,918,747	0	1,918,747
53.00	05300	ANESTHESIOLOGY	136,879		136,879	0	136,879
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,471,426		2,471,426	0	2,471,426
60.00	06000	LABORATORY	3,240,759		3,240,759	0	3,240,759
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	513,110	0	513,110	0	513,110
66.00	06600	PHYSICAL THERAPY	991,405	0	991,405	0	991,405
67.00	06700	OCCUPATIONAL THERAPY	219,648	0	219,648	0	219,648
68.00	06800	SPEECH PATHOLOGY	197,766	0	197,766	0	197,766
69.00	06900	ELECTROCARDIOLOGY	66,806		66,806	0	66,806
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	899,110		899,110	0	899,110
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,131		67,131	0	67,131
73.00	07300	DRUGS CHARGED TO PATIENTS	1,885,243		1,885,243	0	1,885,243
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	546,987		546,987	0	546,987
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,283,170		7,283,170	0	7,283,170
90.00	09000	CLINIC	649,217		649,217	0	649,217
90.01	09001	WOUND CARE	0		0	0	0
90.02	09002	CLINIC	385,497		385,497	0	385,497
90.03	09003	URGENT CARE	0		0	0	0
90.04	09004	CISNE CLINIC	0		0	0	0
91.00	09100	EMERGENCY	2,614,789		2,614,789	0	2,614,789
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,126,870		1,126,870	0	1,126,870
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	825,112		825,112		825,112
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	31,680,265	0	31,680,265	0	31,680,265
201.00		Less Observation Beds	1,126,870		1,126,870		1,126,870
202.00		Total (see instructions)	30,553,395	0	30,553,395	0	30,553,395

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/1/2021 8:41 am

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,640,024		3,640,024			30.00
31.00	03100	INTENSIVE CARE UNIT	243,960		243,960			31.00
44.00	04400	SKILLED NURSING FACILITY	1,426,204		1,426,204			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,230,284	10,935,138	12,165,422	0.157721	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	5,734	30,974	36,708	3.728860	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,100	19,371,698	20,120,798	0.122829	0.000000	54.00
60.00	06000	LABORATORY	1,038,123	14,554,703	15,592,826	0.207837	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,691,276	1,966,096	3,657,372	0.140295	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	327,145	1,615,427	1,942,572	0.510357	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	348,204	152,638	500,842	0.438557	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	70,355	237,162	307,517	0.643106	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	168,129	988,796	1,156,925	0.057744	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	798,745	3,932,773	4,731,518	0.190026	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,774	202,840	207,614	0.323345	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,343,133	4,518,808	5,861,941	0.321607	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,121,439	1,121,439	0.487755	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,051,398	5,051,398			88.00
90.00	09000	CLINIC	0	638,552	638,552	1.016702	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	283,235	283,235	1.361050	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0.000000	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	51,423	3,494,495	3,545,918	0.737408	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	123,124	1,047,855	1,170,979	0.962332	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	516,877	516,877			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,259,737	70,660,904	83,920,641			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,259,737	70,660,904	83,920,641			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.157721		50.00
53.00	05300	ANESTHESIOLOGY	3.728860		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122829		54.00
60.00	06000	LABORATORY	0.207837		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.140295		65.00
66.00	06600	PHYSICAL THERAPY	0.510357		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438557		67.00
68.00	06800	SPEECH PATHOLOGY	0.643106		68.00
69.00	06900	ELECTROCARDIOLOGY	0.057744		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.190026		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323345		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321607		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.487755		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1.016702		90.00
90.01	09001	WOUND CARE	0.000000		90.01
90.02	09002	CLINIC	1.361050		90.02
90.03	09003	URGENT CARE	0.000000		90.03
90.04	09004	CISNE CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.737408		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.962332		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,099,634		3,099,634	0
31.00	03100	INTENSIVE CARE UNIT	289,332		289,332	0
44.00	04400	SKILLED NURSING FACILITY	2,251,627		2,251,627	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,918,747		1,918,747	0
53.00	05300	ANESTHESIOLOGY	136,879		136,879	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,471,426		2,471,426	0
60.00	06000	LABORATORY	3,240,759		3,240,759	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	513,110	0	513,110	0
66.00	06600	PHYSICAL THERAPY	991,405	0	991,405	0
67.00	06700	OCCUPATIONAL THERAPY	219,648	0	219,648	0
68.00	06800	SPEECH PATHOLOGY	197,766	0	197,766	0
69.00	06900	ELECTROCARDIOLOGY	66,806		66,806	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	899,110		899,110	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,131		67,131	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,885,243		1,885,243	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	546,987		546,987	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,283,170		7,283,170	0
90.00	09000	CLINIC	649,217		649,217	0
90.01	09001	WOUND CARE	0		0	0
90.02	09002	CLINIC	385,497		385,497	0
90.03	09003	URGENT CARE	0		0	0
90.04	09004	CISNE CLINIC	0		0	0
91.00	09100	EMERGENCY	2,614,789		2,614,789	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	825,112		825,112	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	30,553,395	0	30,553,395	0
201.00		Less Observation Beds	0		0	0
202.00		Total (see instructions)	30,553,395	0	30,553,395	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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			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	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0.000000	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CARE	0.000000			90.01
90.02	09002	CLINIC	0.000000			90.02
90.03	09003	URGENT CARE	0.000000			90.03
90.04	09004	CISNE CLINIC	0.000000			90.04
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	138,953	12,165,422	0.011422	578,920	6,612	50.00
53.00	05300 ANESTHESIOLOGY	4,971	36,708	0.135420	5,734	776	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	115,354	20,120,798	0.005733	560,478	3,213	54.00
60.00	06000 LABORATORY	84,648	15,592,826	0.005429	683,403	3,710	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	36,678	3,657,372	0.010029	839,160	8,416	65.00
66.00	06600 PHYSICAL THERAPY	59,296	1,942,572	0.030524	32,109	980	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,682	500,842	0.029315	28,494	835	67.00
68.00	06800 SPEECH PATHOLOGY	9,755	307,517	0.031722	28,711	911	68.00
69.00	06900 ELECTROCARDIOLOGY	1,341	1,156,925	0.001159	54,262	63	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	41,672	4,731,518	0.008807	624,533	5,500	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	791	207,614	0.003810	1,276	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,069	5,861,941	0.011783	723,786	8,528	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,845	1,121,439	0.032855	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	576,389	5,051,398	0.114105	0	0	88.00
90.00	09000 CLINIC	7,762	638,552	0.012156	0	0	90.00
90.01	09001 WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002 CLINIC	23,265	283,235	0.082140	0	0	90.02
90.03	09003 URGENT CARE	0	0	0.000000	0	0	90.03
90.04	09004 CISNE CLINIC	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	79,815	3,545,918	0.022509	22,156	499	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	107,314	1,170,979	0.091645	14,881	1,364	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00	Total (lines 50 through 199)	1,408,600	78,093,576		4,197,903	41,412	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CARE	0	0	0	0	0 90.01
90.02	09002	CLINIC	0	0	0	0	0 90.02
90.03	09003	URGENT CARE	0	0	0	0	0 90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1311		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 2/1/2021 8:41 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	12,165,422	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	36,708	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	20,120,798	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	15,592,826	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,657,372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,942,572	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	500,842	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	307,517	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,156,925	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,731,518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	207,614	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,861,941	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	1,121,439	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	5,051,398	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	638,552	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	283,235	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	0	3,545,918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	1,170,979	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	78,093,576		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311

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

Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

			Title XVIII		Hospital		Cost
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	578,920	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,734	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	560,478	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	683,403	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	839,160	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	32,109	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,494	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	28,711	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	54,262	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	624,533	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,276	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	723,786	0	0	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0 90.01
90.02	09002	CLINIC	0.000000	0	0	0	0 90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0 90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0 90.04
91.00	09100	EMERGENCY	0.000000	22,156	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	14,881	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00		Total (lines 50 through 199)		4,197,903	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
2/1/2021 8:41 am

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.157721	0	4,195,017	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	3.728860	0	13,358	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122829	0	8,974,858	0	0	54.00	
60.00	06000	LABORATORY	0.207837	0	5,969,961	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.140295	0	820,007	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.510357	0	565,147	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.438557	0	41,963	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.643106	0	15,446	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.057744	0	518,415	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.190026	0	1,565,874	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323345	0	105,147	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321607	0	2,469,557	1,232	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.487755	0	1,072,310	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
90.00	09000	CLINIC	1.016702	0	0	0	0	90.00	
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01	
90.02	09002	CLINIC	1.361050	0	106,718	0	0	90.02	
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03	
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04	
91.00	09100	EMERGENCY	0.737408	0	1,324,462	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.962332	0	528,828	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Subtotal (see instructions)		0	28,287,068	1,232	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	28,287,068	1,232	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
2/1/2021 8:41 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	661,642	0		50.00
53.00	05300	ANESTHESIOLOGY	49,810	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,102,373	0		54.00
60.00	06000	LABORATORY	1,240,779	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	115,043	0		65.00
66.00	06600	PHYSICAL THERAPY	288,427	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,403	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,933	0		68.00
69.00	06900	ELECTROCARDIOLOGY	29,935	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	297,557	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,999	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	794,227	396		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	523,025	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	145,249	0		90.02
90.03	09003	URGENT CARE	0	0		90.03
90.04	09004	CISNE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	976,669	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	508,908	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	6,795,979	396		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,795,979	396		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311
Component CCN: 14-5552

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

Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	URGENT CARE	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1311 Component CCN: 14-5552		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 2/1/2021 8:41 am	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,165,422	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	36,708	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,120,798	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,592,826	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,657,372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,942,572	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	500,842	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	307,517	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,156,925	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,731,518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	207,614	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,861,941	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,121,439	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,051,398	0.000000	88.00
90.00	09000	CLINIC	0	0	0	638,552	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	283,235	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	3,545,918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,170,979	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	78,093,576		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311
Component CCN: 14-5552

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

Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	47,684	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	38,848	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	190,514	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	235,192	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	262,463	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,940	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,283	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	174,212	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	174,672	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		1,158,808	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1311 Component CCN: 14-5552		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 2/1/2021 8:41 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.157721	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	3.728860	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122829	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.207837	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.140295	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.510357	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438557	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.643106	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057744	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.190026	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323345	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321607	0	0	0	4,094	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.487755	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	1.016702	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	0	90.01
90.02	09002	CLINIC	1.361050	0	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.737408	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.962332	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	0	4,094	0	200.00
201.00		Less PBP Clinic Lab. Services-Program				0	0		201.00
202.00		Only Charges							
		Net Charges (line 200 - line 201)		0	0	0	4,094	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1311 Component CCN:14-5552		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 2/1/2021 8:41 am		
			Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	1,317					73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	WOUND CARE	0	0					90.01
90.02	09002	CLINIC	0	0					90.02
90.03	09003	URGENT CARE	0	0					90.03
90.04	09004	CISNE CLINIC	0	0					90.04
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0					93.99
200.00		Subtotal (see instructions)	0	1,317					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	1,317					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
2/1/2021 8:41 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	295,184	0	295,184	2,107	140.10	30.00
31.00	INTENSIVE CARE UNIT	26,602		26,602	164	162.21	31.00
44.00	SKILLED NURSING FACILITY	182,794		182,794	7,972	22.93	44.00
200.00	Total (lines 30 through 199)	504,580		504,580	10,243		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	35	4,904				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	35	4,904				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	138,953	0	0.000000	0	0	50.00
53.00	05300 ANESTHESIOLOGY	4,971	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	115,354	0	0.000000	0	0	54.00
60.00	06000 LABORATORY	84,648	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	36,678	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	59,296	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,682	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	9,755	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,341	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	41,672	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	791	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,069	0	0.000000	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,845	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	576,389	0	0.000000	0	0	88.00
90.00	09000 CLINIC	7,762	0	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002 CLINIC	23,265	0	0.000000	0	0	90.02
90.03	09003 URGENT CARE	0	0	0.000000	0	0	90.03
90.04	09004 CISNE CLINIC	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	79,815	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00	Total (lines 50 through 199)	1,301,286	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1311		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 2/1/2021 8:41 am	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	2,107	0.00	35	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	164	0.00	0	31.00		
44.00	04400	SKILLED NURSING FACILITY		0	7,972	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	10,243		35	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311

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

 Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			Title XIX		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CARE	0	0	0	0	0 90.01
90.02	09002	CLINIC	0	0	0	0	0 90.02
90.03	09003	URGENT CARE	0	0	0	0	0 90.03
90.04	09004	CISNE CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Title XIX		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	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	90.02
90.03	09003	URGENT CARE	0	0	0	0.000000	90.03
90.04	09004	CISNE CLINIC	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1311

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

Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description			Title XIX		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	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	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	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,107	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)		1,341	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		909	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,099,634	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,099,634	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)		3,099,634	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,471.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,337,239	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)		1,337,239	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1311

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

Worksheet D-1

Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	289,332	164	1,764.22	57	100,561	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)					874,302	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,312,102	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					766	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,471.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,126,870	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1311

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

Worksheet D-1

Date/Time Prepared:
2/1/2021 8:41 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	295,184	3,099,634	0.095232	1,126,870	107,314
91.00	Nursing School cost	0	3,099,634	0.000000	1,126,870	0
92.00	Allied health cost	0	3,099,634	0.000000	1,126,870	0
93.00	All other Medical Education	0	3,099,634	0.000000	1,126,870	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,972	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,972	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)		7,972	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		966	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,251,627	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,251,627	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)		2,251,627	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/1/2021 8:41 am
				Title XVIII	Skilled Nursing Facility	PPS
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)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					2,251,627	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					282.44	71.00
72.00 Program routine service cost (line 9 x line 71)					272,837	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					272,837	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					272,837	83.00
84.00 Program inpatient ancillary services (see instructions)					386,393	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					659,230	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1311 Component CCN:14-5552		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 2/1/2021 8:41 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 2/1/2021 8:41 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,178,973		30.00
31.00	03100	INTENSIVE CARE UNIT		121,980		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.157721	578,920	91,308	50.00
53.00	05300	ANESTHESIOLOGY	3.728860	5,734	21,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122829	560,478	68,843	54.00
60.00	06000	LABORATORY	0.207837	683,403	142,036	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.140295	839,160	117,730	65.00
66.00	06600	PHYSICAL THERAPY	0.510357	32,109	16,387	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438557	28,494	12,496	67.00
68.00	06800	SPEECH PATHOLOGY	0.643106	28,711	18,464	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057744	54,262	3,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.190026	624,533	118,678	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.323345	1,276	413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321607	723,786	232,775	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.487755	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.016702	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	CLINIC	1.361050	0	0	90.02
90.03	09003	URGENT CARE	0.000000	0	0	90.03
90.04	09004	CISNE CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.737408	22,156	16,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.962332	14,881	14,320	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,197,903	874,302	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		4,197,903		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 2/1/2021 8:41 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157721	0	0	50.00
53.00	05300 ANESTHESIOLOGY	3.728860	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122829	47,684	5,857	54.00
60.00	06000 LABORATORY	0.207837	38,848	8,074	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.140295	190,514	26,728	65.00
66.00	06600 PHYSICAL THERAPY	0.510357	235,192	120,032	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.438557	262,463	115,105	67.00
68.00	06800 SPEECH PATHOLOGY	0.643106	32,940	21,184	68.00
69.00	06900 ELECTROCARDIOLOGY	0.057744	2,283	132	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.190026	174,212	33,105	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.323345	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.321607	174,672	56,176	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.487755	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.016702	0	0	90.00
90.01	09001 WOUND CARE	0.000000	0	0	90.01
90.02	09002 CLINIC	1.361050	0	0	90.02
90.03	09003 URGENT CARE	0.000000	0	0	90.03
90.04	09004 CISNE CLINIC	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.737408	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.962332	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,158,808	386,393	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)		1,158,808		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,796,375 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)			6,796,375 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)			6,864,339 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)			106,583 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,443,431 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,314,325 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,314,325 30.00
31.00	Primary payer payments			2,427 31.00
32.00	Subtotal (line 30 minus line 31)			2,311,898 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)			1,091,795 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			709,667 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			900,909 36.00
37.00	Subtotal (see instructions)			3,021,565 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,021,565 40.00
40.01	Sequestration adjustment (see instructions)			50,460 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			2,874,838 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)			96,267 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,317	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		1,317	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,094	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)		4,094	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)		4,094	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,777	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)		1,317	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)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		1,317	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)		1,317	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,317	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,317	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			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)		1,317	40.00
40.01	Sequestration adjustment (see instructions)		22	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		802	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		493	43.00
43.01	Balance due provider/program-PARHM (see instructions)			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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
2/1/2021 8:41 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,652,378		2,874,838	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	02/13/2020	54,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		54,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,706,478		2,874,838	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		288,620		96,267	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,995,098		2,971,105	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-1311 Component CCN: 14-5552		Period: From 07/01/2019 To 06/30/2020		Worksheet E-1 Part I Date/Time Prepared: 2/1/2021 8:41 am	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		393,990		802	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		393,990		802	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		493	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		393,990		1,295	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
2/1/2021 8:41 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1311	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,312,102	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)		2,312,102	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,335,223	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)		2,335,223	19.00
20.00	Deductibles (exclude professional component)		345,048	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,990,175	22.00
23.00	Coinsurance		11,957	23.00
24.00	Subtotal (line 22 minus line 23)		1,978,218	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		78,098	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		50,764	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,040	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,028,982	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)		2,028,982	30.00
30.01	Sequestration adjustment (see instructions)		33,884	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		1,706,478	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)		288,620	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		470,067	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		470,067	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		68,503	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		401,564	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		401,564	15.00
15.01	Sequestration adjustment (see instructions)		7,574	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		393,990	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-1311

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

Worksheet G

Date/Time Prepared:
2/1/2021 8:41 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,387,255	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,892,496	0	0	0	4.00
5.00	Other receivable	1,121,253	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,913,309	0	0	0	6.00
7.00	Inventory	688,554	0	0	0	7.00
8.00	Prepaid expenses	358,830	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-2,169,575	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,365,504	0	0	0	11.00
FIXED ASSETS						
12.00	Land	449,428	0	0	0	12.00
13.00	Land improvements	657,953	0	0	0	13.00
14.00	Accumulated depreciation	-638,038	0	0	0	14.00
15.00	Buildings	19,910,829	0	0	0	15.00
16.00	Accumulated depreciation	-14,972,852	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	2,164,322	0	0	0	19.00
20.00	Accumulated depreciation	-1,498,664	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	17,267,519	0	0	0	23.00
24.00	Accumulated depreciation	-10,782,893	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,378,156	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,935,760	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,702,549	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,702,549	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,003,813	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	562,184	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,152,918	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	548,137	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	203,211	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,466,450	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	726,855	0	0	0	46.00
47.00	Notes payable	5,245,425	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)	5,972,280	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,438,730	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,565,083				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,565,083	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,003,813	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1311

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

Worksheet G-1

Date/Time Prepared:
2/1/2021 8:41 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,606,519		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,958,564				2.00
3.00	Total (sum of line 1 and line 2)		19,565,083		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,565,083		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,565,083		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1311

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
2/1/2021 8:41 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,640,024		3,640,024	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,426,204		1,426,204	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)	5,066,228		5,066,228	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	243,960		243,960	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)	243,960		243,960	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,310,188		5,310,188	17.00
18.00	Ancillary services	7,642,640	59,760,854	67,403,494	18.00
19.00	Outpatient services	174,547	5,464,137	5,638,684	19.00
20.00	RURAL HEALTH CLINIC	0	5,051,398	5,051,398	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		516,877	516,877	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	288,485	5,918,244	6,206,729	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,415,860	76,711,510	90,127,370	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,504,954		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)		34,504,954		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1311

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

Worksheet G-3

Date/Time Prepared:
2/1/2021 8:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,127,370	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,512,368	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,615,002	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,504,954	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,889,952	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	603,778	6.00
7.00	Income from investments	53,080	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	9,318	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	172,814	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,176	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	247,285	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	315,657	24.00
24.50	COVID-19 PHE Funding	7,433,408	24.50
25.00	Total other income (sum of lines 6-24)	8,848,516	25.00
26.00	Total (line 5 plus line 25)	2,958,564	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)	2,958,564	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1311

Period: From 07/01/2019

Worksheet H

HHA CCN: 14-7612

To 06/30/2020

Date/Time Prepared: 2/1/2021 8:41 am

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0 1.00
2.00 Capital Related - Movable Equipment			0		0	0 2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0 3.00
4.00 Transportation	0	0	0	0	0	0 4.00
5.00 Administrative and General	122,462	0	44,577	0	37,196	204,235 5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	225,339	0	0	0	0	225,339 6.00
7.00 Physical Therapy	0	0	0	0	0	0 7.00
8.00 Occupational Therapy	0	0	0	0	0	0 8.00
9.00 Speech Pathology	0	0	0	0	0	0 9.00
10.00 Medical Social Services	0	0	0	0	0	0 10.00
11.00 Home Health Aide	0	0	0	0	0	0 11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0 12.00
13.00 Drugs	0	0	0	0	0	0 13.00
14.00 DME	0	0	0	0	0	0 14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0 15.00
16.00 Respiratory Therapy	0	0	0	0	0	0 16.00
17.00 Private Duty Nursing	0	0	0	0	0	0 17.00
18.00 Clinic	0	0	0	0	0	0 18.00
19.00 Health Promotion Activities	0	0	0	0	0	0 19.00
20.00 Day Care Program	0	0	0	0	0	0 20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0 21.00
22.00 Homemaker Service	0	0	0	0	0	0 22.00
23.00 All Others (specify)	0	0	0	0	0	0 23.00
23.50 Telemedicine	0	0	0	0	0	0 23.50
24.00 Total (sum of lines 1-23)	347,801	0	44,577	0	37,196	429,574 24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	0	0	0	0		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	0	204,235	0	204,235		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	225,339	0	225,339		6.00
7.00 Physical Therapy	44,804	44,804	0	44,804		7.00
8.00 Occupational Therapy	14,021	14,021	0	14,021		8.00
9.00 Speech Pathology	3,548	3,548	0	3,548		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Home Health Aide	0	0	0	0		11.00
12.00 Supplies (see instructions)	0	0	0	0		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	62,373	491,947	0	491,947		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1311

Period:

Worksheet H-1

HHA CCN: 14-7612

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
2/1/2021 8:41 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n		
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	204,235	0	0	0	0	204,235	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	225,339	0	0	0	0	225,339	6.00
7.00	Physical Therapy	44,804	0	0	0	0	44,804	7.00
8.00	Occupational Therapy	14,021	0	0	0	0	14,021	8.00
9.00	Speech Pathology	3,548	0	0	0	0	3,548	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	491,947	0	0	0	0	491,947	24.00
		Administrativ e & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	204,235						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	159,958	385,297					6.00
7.00	Physical Therapy	31,805	76,609					7.00
8.00	Occupational Therapy	9,953	23,974					8.00
9.00	Speech Pathology	2,519	6,067					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		491,947					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1311

Period:

Worksheet H-1

HHA CCN: 14-7612

From 07/01/2019

Part II

To 06/30/2020

Date/Time Prepared:

2/1/2021 8:41 am

Home Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-204,235	287,712	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	225,339	6.00
7.00	Physical Therapy	0	0	0	0	0	44,804	7.00
8.00	Occupational Therapy	0	0	0	0	0	14,021	8.00
9.00	Speech Pathology	0	0	0	0	0	3,548	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-204,235	287,712	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		204,235	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.709859	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311

Period:

Worksheet H-2

HHA CCN: 14-7612

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
2/1/2021 8:41 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	21,669	9,182	9,610	40,461	6,735	1.00
2.00	Skilled Nursing Care	385,297	0	0	61,765	447,062	74,410	2.00
3.00	Physical Therapy	76,609	0	0	972	77,581	12,913	3.00
4.00	Occupational Therapy	23,974	0	0	3,843	27,817	4,630	4.00
5.00	Speech Pathology	6,067	0	0	12,281	18,348	3,054	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	23,957	23,957	3,988	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	491,947	21,669	9,182	112,428	635,226	105,730	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	20,167	17,418	0	17,001	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	20,167	17,418	0	17,001	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311

Period:

Worksheet H-2

HHA CCN: 14-7612

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
2/1/2021 8:41 amHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	29,570	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	29,570	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		19.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	131,352	0	131,352			1.00
2.00	Skilled Nursing Care	0	521,472	0	521,472	98,732	620,204	2.00
3.00	Physical Therapy	0	90,494	0	90,494	17,134	107,628	3.00
4.00	Occupational Therapy	0	32,447	0	32,447	6,143	38,590	4.00
5.00	Speech Pathology	0	21,402	0	21,402	4,052	25,454	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	27,945	0	27,945	5,291	33,236	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	825,112	0	825,112	131,352	825,112	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.189333		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311
HHA CCN: 14-7612Period:
From 07/01/2019
To 06/30/2020Worksheet H-2
Part II
Date/Time Prepared:
2/1/2021 8:41 am

						Home Health Agency I	2/17/2021 8:41 am PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,920	1,920	35,060	0	40,461	1,920	1.00
2.00	Skilled Nursing Care	0	0	225,339	0	447,062	0	2.00
3.00	Physical Therapy	0	0	3,548	0	77,581	0	3.00
4.00	Occupational Therapy	0	0	14,021	0	27,817	0	4.00
5.00	Speech Pathology	0	0	44,804	0	18,348	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	87,402	0	23,957	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	1,920	410,174		635,226	1,920	20.00
21.00	Total cost to be allocated	21,669	9,182	112,428		105,730	20,167	21.00
22.00	Unit cost multiplier	11.285937	4.782292	0.274098		0.166445	10.503646	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	1,920	0	1,920	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00	Total cost to be allocated	17,418	0	17,001	0	0	0	21.00
22.00	Unit cost multiplier	9.071875	0.000000	8.854687	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311

Period:

Worksheet H-2

HHA CCN: 14-7612

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
2/1/2021 8:41 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NRS ING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (ASSIGNED TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	13,421	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	13,421	0	0	0	0	0	20.00
21.00	Total cost to be allocated	29,570	0	0	0	0	0	21.00
22.00	Unit cost multiplier	2.203264	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311

Period:

Worksheet H-3

HHA CCN: 14-7612

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
2/1/2021 8:41 am

				Title XVIII		Home Health Agency I	2/17/2021 8:41 am PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	620,204		620,204	2,506	247.49	1.00
2.00	Physical Therapy	3.00	107,628	0	107,628	1,015	106.04	2.00
3.00	Occupational Therapy	4.00	38,590	0	38,590	271	142.40	3.00
4.00	Speech Pathology	5.00	25,454	0	25,454	70	363.63	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		791,876	0	791,876	3,862		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
			Not Subject to Deductibles & Coinsurance		Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		14999	0	1,885			8.00
9.00	Physical Therapy		14999	0	859			9.00
10.00	Occupational Therapy		14999	0	226			10.00
11.00	Speech Pathology		14999	0	33			11.00
12.00	Medical Social Services		14999	0	0			12.00
13.00	Home Health Aide		14999	0	0			13.00
14.00	Total (sum of lines 8-13)			0	3,003			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,885		0	466,519		1.00
2.00	Physical Therapy	0	859		0	91,088		2.00
3.00	Occupational Therapy	0	226		0	32,182		3.00
4.00	Speech Pathology	0	33		0	12,000		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	3,003		0	601,789		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311

Period:

Worksheet H-3

HHA CCN: 14-7612

From 07/01/2019

Part I

To 06/30/2020

Date/Time Prepared:

2/1/2021 8:41 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B			Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00		9.00	10.00	11.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	81,083	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	466,519						1.00	
2.00	Physical Therapy	91,088						2.00	
3.00	Occupational Therapy	32,182						3.00	
4.00	Speech Pathology	12,000						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	0						6.00	
7.00	Total (sum of lines 1-6)	601,789						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311

Period:

Worksheet H-3

HHA CCN: 14-7612

From 07/01/2019

Part II

To 06/30/2020

Date/Time Prepared:

2/1/2021 8:41 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.510357	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.438557	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.643106	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.190026	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.321607	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1311 HHA CCN: 14-7612	Period: From 07/01/2019 To 06/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 2/1/2021 8:41 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0 1.00
2.00	Total charges	0	0	0 2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0 3.00
4.00	Amount 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(b)	0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)	0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0 8.00
9.00	Primary payer amounts	0	0	0 9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	382,195 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	69,188 12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	11,815 13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	308 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	27,901 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0 16.00
17.00	Total Other Payments		0	0 17.00
18.00	DME Payments		0	0 18.00
19.00	Oxygen Payments		0	0 19.00
20.00	Prosthetic and Orthotic Payments		0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	491,407 22.00
23.00	Excess reasonable cost (from line 8)		0	0 23.00
24.00	Subtotal (line 22 minus line 23)		0	491,407 24.00
25.00	Coinsurance billed to program patients (from your records)		0	0 25.00
26.00	Net cost (line 24 minus line 25)		0	491,407 26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	491,407 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0 30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0 30.99
31.00	Subtotal (see instructions)		0	491,407 31.00
31.01	Sequestration adjustment (see instructions)		0	8,211 31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0 31.02
32.00	Interim payments (see instructions)		0	483,197 32.00
33.00	Tentative settlement (for contractor use only)		0	0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1311 HHA CCN: 14-7612		Period: From 07/01/2019 To 06/30/2020		Worksheet H-5 Date/Time Prepared: 2/1/2021 8:41 am	
				Home Health Agency I		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		483,197	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			0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50			0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		483,197	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		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		1	6.02	
7.00	Total Medicare program liability (see instructions)		0		483,196	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1311

Period:

Worksheet M-1

Component CCN: 14-8500

From 07/01/2019
To 06/30/2020Date/Time Prepared:
2/1/2021 8:41 am

		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	1,063,369	0	1,063,369	126,690	1,190,059
2.00	Physician Assistant	499,608	0	499,608	-2,677	496,931
3.00	Nurse Practitioner	365,285	0	365,285	0	365,285
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	216,771	0	216,771	-26,220	190,551
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,145,033	0	2,145,033	97,793	2,242,826
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	183,654	183,654	0	183,654
16.00	Transportation (Health Care Staff)	0	16,135	16,135	0	16,135
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	199,789	199,789	0	199,789
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,145,033	199,789	2,344,822	97,793	2,442,615
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	32,908	32,908
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	32,908	32,908
FACILITY OVERHEAD						
29.00	Facility Costs	0	13,100	13,100	0	13,100
30.00	Administrative Costs	1,266,783	323,830	1,590,613	-1,350	1,589,263
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,266,783	336,930	1,603,713	-1,350	1,602,363
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,411,816	536,719	3,948,535	129,351	4,077,886

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1311

Period:

Worksheet M-1

Component CCN: 14-8500

From 07/01/2019
To 06/30/2020Date/Time Prepared:
2/1/2021 8:41 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-48,556	1,141,503	1.00
2.00	Physician Assistant	0	496,931	2.00
3.00	Nurse Practitioner	-34,385	330,900	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	190,551	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-82,941	2,159,885	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	183,654	15.00
16.00	Transportation (Health Care Staff)	0	16,135	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	199,789	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-82,941	2,359,674	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	32,908	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	32,908	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	13,100	29.00
30.00	Administrative Costs	0	1,589,263	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,602,363	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-82,941	3,994,945	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1311

Period:

Worksheet M-2

Component CCN: 14-8500

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

Date/Time Prepared:

2/1/2021 8:41 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.29	10,247	4,200	9,618	1.00
2.00	Physician Assistant	3.78	7,663	2,100	7,938	2.00
3.00	Nurse Practitioner	3.12	5,074	2,100	6,552	3.00
4.00	Subtotal (sum of lines 1 through 3)	9.19	22,984		24,108	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	2.69	2,658		2,658	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)	11.88	25,642		26,766	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,359,674	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				32,908	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,392,582	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.986246	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,602,363	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,288,225	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,890,588	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,890,588	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,823,323	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				7,182,997	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1311 Component CCN: 14-8500	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 2/1/2021 8:41 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,182,997	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			96,834	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7,086,163	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			26,766	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			26,766	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			264.74	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		264.74	264.74	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		3,820	3,099	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,011,307	820,429	11.00
12.00	Program covered visits for mental health services (from contractor records)		274	199	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		72,539	52,683	13.00
14.00	Limit adjustment for mental health services (see instructions)		72,539	52,683	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	1,956,958	16.00
16.01	Total program charges (see instructions)(from contractor's records)			991,585	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			63,055	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			124,443	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.)			1,372,684	16.04
16.05	Total program cost (see instructions)		0	1,497,127	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			116,660	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			162,199	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,497,127	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			57,760	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,554,887	22.00
23.00	Allowable bad debts (see instructions)			154,055	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			100,136	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			99,587	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)			1,655,023	26.00
26.01	Sequestration adjustment (see instructions)			27,639	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			829,739	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)			797,645	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: 14-1311 Component CCN: 14-8500	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 2/1/2021 8:41 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,159,885	2,159,885	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000159	0.000433	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		343	935	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19,823	10,710	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,166	11,645	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,359,674	2,359,674	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,823,323	4,823,323	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008546	0.004935	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		41,220	23,803	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		61,386	35,448	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		140	382	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		438.47	92.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		93	183	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		40,778	16,982	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)			96,834	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)			57,760	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1311 Component CCN: 14-8500	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 2/1/2021 8:41 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		829,739	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		829,739	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		797,645	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,627,384	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00