

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/30/2020 11:55 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2020	Time: 11:55 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANKLIN HOSPITAL (14-1321) 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) JAMES JOHNSON

Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	71,760	214,314	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	55,330	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		236,781		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-4,387		0	10.01
200.00	Total	0	127,090	446,708	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: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 11:55 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 201 BAILEY LANE			PO Box:				1.00		
2.00	City: BENTON			State: IL		Zip Code: 62812		County: FRANKLIN		
		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		FRANKLIN HOSPITAL	141321	99914	1	08/01/2002	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		FRANKLIN HOSPITAL SWING BED	14Z321	99914		08/01/2002	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		FRANKLIN RHC	143469	99914		07/06/2005	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		WEST FRANKFORT RHC	148510	99914		04/23/2010	N	O	N
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		20.00
21.00	Type of Control (see instructions)						9			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/30/2020 11:55 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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 11:55 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/30/2020 11:55 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 11:55 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y	Y	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 11:55 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
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.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	137,355	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 11:55 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							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	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 11:55 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/10/2020	Y	10/10/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/30/2020 11:55 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 11:55 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	7,344.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	7,344.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	7,344.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 11:55 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)	244	2	306			1.00
2.00	HMO and other (see instructions)	6	22				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	270	0	272			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	514	2	580			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)	514	2	580	0.00	129.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,371	666	17,582	0.00	20.87	26.00
26.01	RURAL HEALTH CLINIC II	527	35	1,260	0.00	1.99	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	152.52	27.00
28.00	Observation Bed Days		0	167			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: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 11:55 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	84	1	113	1.00
2.00 HMO and other (see instructions)			0	7		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	84	1	113	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1321
 Component CCN: 14-3469

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

Worksheet S-8

 Date/Time Prepared:
 11/30/2020 11:55 am

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		201 BAILEY LANE		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		BENTON IL 62812		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		12:00	18:00	09:00	20:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		FRANKLIN		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC		20:00	09:00	20:00
		09:00	20:00	09:00	20:00
		11.00			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321
Component CCN: 14-3469Period:
From 07/01/2019
To 06/30/2020

Worksheet S-8

Date/Time Prepared:
11/30/2020 11:55 am

				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	09:00	20:00	09:00	19:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1321
 Component CCN: 14-8510

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

Worksheet S-8

 Date/Time Prepared:
 11/30/2020 11:55 am

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			309 WEST ST. LOUIS STREET		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			WEST FRANKFORT IL 62896		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			09:00		17:00	
				17:00		09:00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
			Y/N	V	XVIII	XIX	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
			County				
			4.00				
2.00	City, State, ZIP Code, County			FRANKLIN		2.00	
			Tuesday		Wednesday		Thursday
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00		09:00	
				17:00		09:00	
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321

Period:

Worksheet S-8

Component CCN: 14-8510

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/30/2020 11:55 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)			0.473276 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			1,763,967 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,900,000		5.00
6.00	Medicaid charges	9,107,984		6.00
7.00	Medicaid cost (line 1 times line 6)	4,310,590		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)	646,623		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)	646,623		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)	134,011	149,264	283,275 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	63,424	149,264	212,688 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)	63,424	149,264	212,688 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)	1,842,733		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	547,015		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	841,561		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,001,172		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	768,377		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	981,065		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,627,688		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet A Date/Time Prepared: 11/30/2020 11:55 am
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	183,966	183,966	178,372	362,338
2.00	00200	CAP REL COSTS-MVBLE EQUIP	612,514	612,514	85,971	698,485
3.00	00300	OTHER CAP REL COSTS	0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	107,285	1,764,867	0	1,872,152
5.00	00500	ADMINISTRATIVE & GENERAL	1,485,381	1,274,740	34,802	2,794,923
6.00	00600	MAINTENANCE & REPAIRS	247,163	162,876	0	410,039
7.00	00700	OPERATION OF PLANT	0	345,725	0	345,725
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,176	0	68,176
9.00	00900	HOUSEKEEPING	232,661	47,383	0	280,044
10.00	01000	DIETARY	189,479	164,266	-306,006	47,739
11.00	01100	CAFETERIA	0	0	306,006	306,006
13.00	01300	NURSING ADMINISTRATION	481,150	48,228	0	529,378
14.00	01400	CENTRAL SERVICE & SUPPLY	89,244	-8,777	0	80,467
15.00	01500	PHARMACY	221,783	1,315,335	-989,764	547,354
16.00	01600	MEDICAL RECORDS & LIBRARY	205,192	81,109	0	286,301
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	898,207	477,787	1,375,994	5,605
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,056	194,726	0	382,782
53.00	05300	ANESTHESIOLOGY	0	22,569	0	22,569
54.00	05400	RADIOLOGY-DIAGNOSTIC	437,809	157,364	-107,234	487,939
57.00	05700	CT SCAN	0	101,627	107,234	208,861
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	55,489	0	55,489
60.00	06000	LABORATORY	401,833	808,953	-4,729	1,206,057
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	27,531	4,729	32,260
65.00	06500	RESPIRATORY THERAPY	233,286	66,346	0	299,632
66.00	06600	PHYSICAL THERAPY	0	216,575	0	216,575
67.00	06700	OCCUPATIONAL THERAPY	0	84,682	0	84,682
68.00	06800	SPEECH PATHOLOGY	0	17,731	0	17,731
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	296,520	0	296,520
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	989,764	989,764
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	156,409	158,079	0	314,488
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,025,119	593,441	-5,605	2,612,955
88.01	08801	RURAL HEALTH CLINIC II	171,211	72,188	0	243,399
91.00	09100	EMERGENCY	680,330	1,863,239	0	2,543,569
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	299,145	-299,145	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,451,598	11,574,400	0	20,025,998
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	386,935	49,881	0	436,816
194.00	07950	340B RETAIL PHARMACY	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	8,838,533	11,624,281	0	20,462,814

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1321

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

Worksheet A

Date/Time Prepared:
11/30/2020 11:55 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	-255	362,083	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-117	698,368	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-14,030	1,858,122	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-78,172	2,716,751	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	410,039	6.00
7.00	00700	OPERATION OF PLANT	-84,286	261,439	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,176	8.00
9.00	00900	HOUSEKEEPING	0	280,044	9.00
10.00	01000	DIETARY	0	47,739	10.00
11.00	01100	CAFETERIA	-101,091	204,915	11.00
13.00	01300	NURSING ADMINISTRATION	0	529,378	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	80,467	14.00
15.00	01500	PHARMACY	-274,510	272,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,540	281,761	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-430,017	951,582	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-79,394	303,388	50.00
53.00	05300	ANESTHESIOLOGY	-16,098	6,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	487,939	54.00
57.00	05700	CT SCAN	0	208,861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	55,489	58.00
60.00	06000	LABORATORY	-375	1,205,682	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	32,260	63.00
65.00	06500	RESPIRATORY THERAPY	-14,737	284,895	65.00
66.00	06600	PHYSICAL THERAPY	0	216,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	-7,963	76,719	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,731	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	296,520	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,741	987,023	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	314,488	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,612,955	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	243,399	88.01
91.00	09100	EMERGENCY	-418,781	2,124,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,527,107	18,498,891	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	436,816	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,527,107	18,935,707	200.00

RECLASSIFICATIONS

Provider CCN: 14-1321

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

Worksheet A-6

Date/Time Prepared:
11/30/2020 11:55 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA COST					
1.00	CAFETERIA	11.00	163,908	142,098	1.00
	0		163,908	142,098	
B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	137,058	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	62,712	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	99,375	3.00
	0		0	299,145	
C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	64,573	1.00
	0		0	64,573	
H - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	989,764	1.00
	0		0	989,764	
J - CT SCAN COSTS					
1.00	CT SCAN	57.00	99,867	7,367	1.00
	0		99,867	7,367	
K - BLOOD					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	4,399	330	1.00
	0		4,399	330	
L - RHC HOSPITALIST TIME					
1.00	ADULTS & PEDIATRICS	30.00	5,272	333	1.00
	TOTALS		5,272	333	
500.00	Grand Total: Increases		273,446	1,503,610	500.00

RECLASSIFICATIONS

Provider CCN: 14-1321

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

Worksheet A-6

Date/Time Prepared:
11/30/2020 11:55 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA COST						
1.00	DIETARY	10.00	163,908	142,098	0	1.00
	0		163,908	142,098		
B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	299,145	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	0		0	299,145		
C - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	64,573	0	1.00
	0		0	64,573		
H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	989,764	0	1.00
	0		0	989,764		
J - CT SCAN COSTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	99,867	7,367	0	1.00
	0		99,867	7,367		
K - BLOOD						
1.00	LABORATORY	60.00	4,399	330	0	1.00
	0		4,399	330		
L - RHC HOSPITALIST TIME						
1.00	RURAL HEALTH CLINIC	88.00	5,272	333	0	1.00
	TOTALS		5,272	333		
500.00	Grand Total: Decreases		273,446	1,503,610		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/30/2020 11:55 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	18,401	0	0	0	0	1.00	
2.00	Land Improvements	145,139	79,985	0	79,985	0	2.00	
3.00	Buildings and Fixtures	5,410,832	0	0	0	0	3.00	
4.00	Building Improvements	5,315,843	665,738	0	665,738	0	4.00	
5.00	Fixed Equipment	3,247,041	0	0	0	0	5.00	
6.00	Movable Equipment	7,486,485	892,387	0	892,387	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	21,623,741	1,638,110	0	1,638,110	0	8.00	
9.00	Reconciling Items	-1,035,733	925,216	0	925,216	0	9.00	
10.00	Total (line 8 minus line 9)	22,659,474	712,894	0	712,894	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,401	0				1.00	
2.00	Land Improvements	225,124	0				2.00	
3.00	Buildings and Fixtures	5,410,832	0				3.00	
4.00	Building Improvements	5,981,581	0				4.00	
5.00	Fixed Equipment	3,247,041	0				5.00	
6.00	Movable Equipment	8,378,872	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	23,261,851	0				8.00	
9.00	Reconciling Items	-110,517	0				9.00	
10.00	Total (line 8 minus line 9)	23,372,368	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/30/2020 11:55 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	183,966	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	612,514	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	796,480	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	183,966				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	612,514				2.00
3.00	Total (sum of lines 1-2)	0	796,480				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/30/2020 11:55 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	14,882,979	0	14,882,979	0.639802	41,314	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,378,872	0	8,378,872	0.360198	23,259	2.00
3.00	Total (sum of lines 1-2)	23,261,851	0	23,261,851	1.000000	64,573	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	41,314	183,966	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	23,259	612,514	0	2.00
3.00	Total (sum of lines 1-2)	0	0	64,573	796,480	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	136,803	41,314	0	0	362,083	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	62,595	23,259	0	0	698,368	2.00
3.00	Total (sum of lines 1-2)	199,398	64,573	0	0	1,060,451	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

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

Worksheet A-8

Date/Time Prepared:
11/30/2020 11:55 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-255	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-117	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-185	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-5,342	ADMINISTRATIVE & GENERAL	5.00	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	-3,213	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,254	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	-946,467			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-576	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	-101,091	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,741	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,540	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	*** Cost Center Deleted ***	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	-7,963	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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		0		0.00	9	32.00
33.00	NH UTILITIES	B	-84,286	OPERATION OF PLANT	7.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

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

Worksheet A-8

Date/Time Prepared:
11/30/2020 11:55 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	
34.00	MISCELLANEOUS INCOME - A&G	B	-29	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MISCELLANEOUS INCOME - LAB	B	-375	LABORATORY	60.00	0	34.01
34.02	MISCELLANEOUS INCOME - OR	B	-2,210	OPERATING ROOM	50.00	0	34.02
35.00	LOBBYING PORTION OF DUES	A	-5,526	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	340B RETAIL PHARMACY COSTS	A	-274,510	PHARMACY	15.00	0	36.00
37.00	ADVERTISING	A	-60,047	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	HOSPITALIST BENEFITS	A	-14,030	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	HOSPITALIST FICA	A	-10,350	ADULTS & PEDIATRICS	30.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,527,107				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1321

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2020 11:55 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	419,667	419,667	0	0	0	1.00
2.00	50.00	OPERATING ROOM	77,184	77,184	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	16,098	16,098	0	0	0	3.00
4.00	60.00	LABORATORY	6,278	0	6,278	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	14,737	14,737	0	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	30,000	0	30,000	0	0	6.00
7.00	91.00	EMERGENCY	1,565,538	418,781	1,146,757	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			2,129,502	946,467	1,183,035		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	419,667		1.00
2.00	50.00	OPERATING ROOM	0	0	0	77,184		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	16,098		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	14,737		5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	418,781		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	946,467		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2020 11:55 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					211	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					155	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	939.47	2,435.30	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	85.53	64.15	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.77	42.77	32.08			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					80,353	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					156,224	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					236,577	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					236,577	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					236,577	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,024	24.00
25.00	Assistants (line 4 times column 3, line 11)					4,972	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,996	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,115	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,111	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,111	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
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				Physical Therapy	Cost		
					1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)				0	46.00	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	85.53	64.15	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					236,577	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,111	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					252,688	63.00
64.00	Total cost of outside supplier services (from your records)					206,918	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					13,996	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,115	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,111	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,115	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,115	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2020 11:55 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					193	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	668.49	223.61	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.06	60.79	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.53	40.53	30.40			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					54,188	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					13,593	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					67,781	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					67,781	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					67,781	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					7,822	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,822	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,116	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,938	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,938	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2020 11:55 am		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.06	60.79	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						67,781	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						8,938	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						76,719	63.00
64.00	Total cost of outside supplier services (from your records)						84,682	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						7,963	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						7,822	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,116	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						8,938	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,116	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						1,116	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2020 11:55 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					125	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	233.60	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.89	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.95	38.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					18,195	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					18,195	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					18,195	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					28,040	22.00
23.00	Total salary equivalency (see instructions)					28,040	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					4,869	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,869	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					723	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,592	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,592	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/30/2020 11:55 am

				Speech Pathology	Cost		
					1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)				0	46.00	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.89	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
					1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					28,040	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					5,592	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					33,632	63.00
64.00	Total cost of outside supplier services (from your records)					17,731	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					4,869	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					723	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					5,592	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					723	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					723	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,083	362,083			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	698,368	698,368			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,858,122	861	4,604	1,863,587	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,716,751	38,270	292,582	323,809	5.00
6.00	00600	MAINTENANCE & REPAIRS	410,039	12,421	5,983	53,881	6.00
7.00	00700	OPERATION OF PLANT	261,439	39,815	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,176	3,413	0	0	8.00
9.00	00900	HOUSEKEEPING	280,044	1,832	0	50,719	9.00
10.00	01000	DIETARY	47,739	22,572	2,100	5,587	10.00
11.00	01100	CAFETERIA	204,915	0	0	35,719	11.00
13.00	01300	NURSING ADMINISTRATION	529,378	3,272	0	104,889	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	80,467	11,523	0	19,455	14.00
15.00	01500	PHARMACY	272,844	4,854	0	48,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	281,761	4,786	3,705	44,731	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	951,582	28,224	50,339	157,158	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	303,388	32,122	15,139	40,996	50.00
53.00	05300	ANESTHESIOLOGY	6,471	470	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,939	12,358	154,634	73,670	54.00
57.00	05700	CT SCAN	208,861	2,834	121,102	21,771	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,489	0	0	0	58.00
60.00	06000	LABORATORY	1,205,682	8,930	6,042	86,639	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	32,260	0	0	959	63.00
65.00	06500	RESPIRATORY THERAPY	284,895	4,629	7,800	50,856	65.00
66.00	06600	PHYSICAL THERAPY	216,575	4,974	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,719	1,247	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,731	219	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	296,520	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	987,023	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	314,488	15,156	0	34,097	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,612,955	53,582	3,200	440,319	88.00
88.01	08801	RURAL HEALTH CLINIC II	243,399	6,905	10,109	37,323	88.01
91.00	09100	EMERGENCY	2,124,788	11,612	21,029	148,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,498,891	326,881	698,368	1,779,236	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	436,816	35,202	0	84,351	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
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)	18,935,707	362,083	698,368	1,863,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,371,412					5.00
6.00	00600	MAINTENANCE & REPAIRS	104,477	586,801				6.00
7.00	00700	OPERATION OF PLANT	65,255	75,237	441,746			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,507	6,450	5,570	99,116		8.00
9.00	00900	HOUSEKEEPING	72,044	3,462	2,989	0	411,090	9.00
10.00	01000	DIETARY	16,895	42,653	36,832	0	0	10.00
11.00	01100	CAFETERIA	52,124	0	0	0	14,156	11.00
13.00	01300	NURSING ADMINISTRATION	138,099	6,183	5,340	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	24,140	21,775	18,804	0	10,182	14.00
15.00	01500	PHARMACY	70,625	9,172	7,920	1,182	10,560	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	72,561	9,043	7,809	0	4,277	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	257,184	53,334	46,055	20,356	74,148	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	84,835	60,701	52,416	9,063	30,772	50.00
53.00	05300	ANESTHESIOLOGY	1,504	888	766	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,824	23,353	20,166	11,643	13,626	54.00
57.00	05700	CT SCAN	76,804	5,355	4,624	2,069	3,142	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,020	0	0	0	0	58.00
60.00	06000	LABORATORY	283,175	16,874	14,571	0	15,897	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	7,196	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	75,420	8,748	7,554	1,156	14,762	65.00
66.00	06600	PHYSICAL THERAPY	47,990	9,399	8,116	9,407	16,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,888	2,357	2,035	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,888	414	358	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,230	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,801	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	78,791	28,639	24,731	1,156	13,891	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	673,675	101,255	87,434	3,678	68,054	88.00
88.01	08801	RURAL HEALTH CLINIC II	64,493	13,047	11,267	1,413	0	88.01
91.00	09100	EMERGENCY	499,451	21,943	18,948	33,913	94,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,250,896	520,282	384,305	95,036	384,292	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120,516	66,519	57,441	4,080	26,798	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	3,371,412	586,801	441,746	99,116	411,090	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	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	174,378					10.00
11.00	01100	CAFETERIA	0	306,914				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,952	804,113			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	6,680	0	193,026		14.00
15.00	01500	PHARMACY	0	8,291	0	905	434,701	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,060	0	586	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	140,650	44,075	205,407	4,896	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,996	41,927	7,560	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	247	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,459	127,970	877	0	54.00
57.00	05700	CT SCAN	0	739	3,442	4,128	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	266	0	58.00
60.00	06000	LABORATORY	0	32,863	153,157	84,233	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	269	1,252	1,238	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	12,823	59,761	2,836	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	795	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	64,446	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	434,701	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	33,728	8,929	41,614	288	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	69,855	0	5,574	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	546	0	88.01
91.00	09100	EMERGENCY	0	36,388	169,583	12,804	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,378	292,379	804,113	192,225	434,701	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,535	0	801	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	174,378	306,914	804,113	193,026	434,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	447,319				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,635	2,043,043	0	2,043,043	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,673	705,588	0	705,588	50.00
53.00	05300	ANESTHESIOLOGY	336	10,682	0	10,682	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,169	1,150,688	0	1,150,688	54.00
57.00	05700	CT SCAN	69,306	524,177	0	524,177	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,753	70,528	0	70,528	58.00
60.00	06000	LABORATORY	106,336	2,014,399	0	2,014,399	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	643	43,817	0	43,817	63.00
65.00	06500	RESPIRATORY THERAPY	19,779	551,019	0	551,019	65.00
66.00	06600	PHYSICAL THERAPY	16,082	329,349	0	329,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,025	103,271	0	103,271	67.00
68.00	06800	SPEECH PATHOLOGY	706	23,316	0	23,316	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,743	430,939	0	430,939	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,756	1,682,281	0	1,682,281	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,961	603,469	0	603,469	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	34,537	4,154,118	0	4,154,118	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,350	390,852	0	390,852	88.01
91.00	09100	EMERGENCY	63,529	3,257,112	0	3,257,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	447,319	18,088,648	0	18,088,648	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	847,059	0	847,059	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	447,319	18,935,707	0	18,935,707	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	861	4,604	5,465	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,471	38,270	292,582	336,323	5.00
6.00	00600	MAINTENANCE & REPAIRS	-332	12,421	5,983	18,072	6.00
7.00	00700	OPERATION OF PLANT	370	39,815	0	40,185	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,413	0	3,413	8.00
9.00	00900	HOUSEKEEPING	0	1,832	0	1,832	9.00
10.00	01000	DIETARY	0	22,572	2,100	24,672	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,272	0	3,272	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,363	11,523	0	12,886	14.00
15.00	01500	PHARMACY	0	4,854	0	4,854	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,026	4,786	3,705	9,517	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,831	28,224	50,339	80,394	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59,419	32,122	15,139	106,680	50.00
53.00	05300	ANESTHESIOLOGY	283	470	0	753	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360	12,358	154,634	167,352	54.00
57.00	05700	CT SCAN	0	2,834	121,102	123,936	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	43,287	8,930	6,042	58,259	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,561	4,629	7,800	16,990	65.00
66.00	06600	PHYSICAL THERAPY	0	4,974	0	4,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,247	0	1,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	219	0	219	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	436	15,156	0	15,592	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,126	53,582	3,200	58,908	88.00
88.01	08801	RURAL HEALTH CLINIC II	413	6,905	10,109	17,427	88.01
91.00	09100	EMERGENCY	1,017	11,612	21,029	33,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,631	326,881	698,368	1,146,880	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	377	35,202	0	35,579	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	122,008	362,083	698,368	1,182,459	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	337,272				5.00
6.00	00600	MAINTENANCE & REPAIRS	10,452	28,682			6.00
7.00	00700	OPERATION OF PLANT	6,528	3,677	50,390		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,551	315	635	5,914	8.00
9.00	00900	HOUSEKEEPING	7,207	169	341	0	9,698
10.00	01000	DIETARY	1,690	2,085	4,201	0	0
11.00	01100	CAFETERIA	5,215	0	0	0	334
13.00	01300	NURSING ADMINISTRATION	13,815	302	609	0	0
14.00	01400	CENTRAL SERVICE & SUPPLY	2,415	1,064	2,145	0	240
15.00	01500	PHARMACY	7,065	448	903	70	249
16.00	01600	MEDICAL RECORDS & LIBRARY	7,259	442	891	0	101
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,729	2,607	5,253	1,215	1,749
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,487	2,967	5,979	541	726
53.00	05300	ANESTHESIOLOGY	150	43	87	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,789	1,141	2,300	695	321
57.00	05700	CT SCAN	7,683	262	527	123	74
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,202	0	0	0	0
60.00	06000	LABORATORY	28,329	825	1,662	0	375
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	720	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,545	428	862	69	348
66.00	06600	PHYSICAL THERAPY	4,801	459	926	561	378
67.00	06700	OCCUPATIONAL THERAPY	1,690	115	232	0	0
68.00	06800	SPEECH PATHOLOGY	389	20	41	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,426	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	21,389	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,882	1,400	2,821	69	328
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	67,390	4,951	9,977	219	1,605
88.01	08801	RURAL HEALTH CLINIC II	6,452	638	1,285	84	0
91.00	09100	EMERGENCY	49,965	1,073	2,161	2,025	2,238
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,215	25,431	43,838	5,671	9,066
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,057	3,251	6,552	243	632
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	337,272	28,682	50,390	5,914	9,698

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	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	32,664					10.00
11.00	01100	CAFETERIA	0	5,654				11.00
13.00	01300	NURSING ADMINISTRATION	0	312	18,617			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	123	0	18,930		14.00
15.00	01500	PHARMACY	0	153	0	89	13,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	333	0	57	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,346	812	4,755	480	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	166	971	741	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	506	2,963	86	0	54.00
57.00	05700	CT SCAN	0	14	80	405	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	26	0	58.00
60.00	06000	LABORATORY	0	605	3,546	8,262	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	5	29	121	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	236	1,384	278	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	78	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,320	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,973	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,318	164	963	28	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,287	0	547	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	53	0	88.01
91.00	09100	EMERGENCY	0	670	3,926	1,256	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,664	5,386	18,617	18,851	13,973	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	268	0	79	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	32,664	5,654	18,617	18,930	13,973	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,731				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	403	150,204	0	150,204	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	740	128,118	0	128,118	50.00
53.00	05300	ANESTHESIOLOGY	14	1,071	0	1,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,640	193,009	0	193,009	54.00
57.00	05700	CT SCAN	2,902	136,070	0	136,070	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	115	1,343	0	1,343	58.00
60.00	06000	LABORATORY	4,456	106,573	0	106,573	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	27	905	0	905	63.00
65.00	06500	RESPIRATORY THERAPY	828	29,117	0	29,117	65.00
66.00	06600	PHYSICAL THERAPY	673	12,850	0	12,850	66.00
67.00	06700	OCCUPATIONAL THERAPY	169	3,453	0	3,453	67.00
68.00	06800	SPEECH PATHOLOGY	30	699	0	699	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	240	12,986	0	12,986	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,957	37,319	0	37,319	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	333	35,998	0	35,998	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,446	147,623	0	147,623	88.00
88.01	08801	RURAL HEALTH CLINIC II	98	26,146	0	26,146	88.01
91.00	09100	EMERGENCY	2,660	100,067	0	100,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,731	1,123,551	0	1,123,551	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	58,908	0	58,908	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,731	1,182,459	0	1,182,459	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,379					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		675,226				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	165	4,451	8,548,688			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,333	282,887	1,485,381	-3,371,412	15,564,295	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,380	5,785	247,163	0	482,324	6.00
7.00	00700	OPERATION OF PLANT	7,629	0	0	0	301,254	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	0	0	0	71,589	8.00
9.00	00900	HOUSEKEEPING	351	0	232,661	0	332,595	9.00
10.00	01000	DIETARY	4,325	2,030	25,628	0	77,998	10.00
11.00	01100	CAFETERIA	0	0	163,851	0	240,634	11.00
13.00	01300	NURSING ADMINISTRATION	627	0	481,150	0	637,539	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	0	89,244	0	111,445	14.00
15.00	01500	PHARMACY	930	0	221,783	0	326,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	3,582	205,192	0	334,983	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,408	48,671	720,919	0	1,187,303	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,155	14,637	188,056	0	391,645	50.00
53.00	05300	ANESTHESIOLOGY	90	0	0	0	6,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	149,510	337,942	0	728,601	54.00
57.00	05700	CT SCAN	543	117,089	99,867	0	354,568	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	55,489	58.00
60.00	06000	LABORATORY	1,711	5,842	397,434	0	1,307,293	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	4,399	0	33,219	63.00
65.00	06500	RESPIRATORY THERAPY	887	7,542	233,286	0	348,180	65.00
66.00	06600	PHYSICAL THERAPY	953	0	0	0	221,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	239	0	0	0	77,966	67.00
68.00	06800	SPEECH PATHOLOGY	42	0	0	0	17,950	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	296,520	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	987,023	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	0	156,409	0	363,741	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,267	3,094	2,019,847	0	3,110,056	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	9,774	171,211	0	297,736	88.01
91.00	09100	EMERGENCY	2,225	20,332	680,330	0	2,305,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,634	675,226	8,161,753	-3,371,412	15,007,926	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	0	386,935	0	556,369	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	362,083	698,368	1,863,587		3,371,412	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.218914	1.034273	0.217997		0.216612	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,465		337,272	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000639		0.021670	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: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	59,501					6.00
7.00	00700	OPERATION OF PLANT	7,629	51,872				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	77,176			8.00
9.00	00900	HOUSEKEEPING	351	351	0	10,861		9.00
10.00	01000	DIETARY	4,325	4,325	0	0	4,012	10.00
11.00	01100	CAFETERIA	0	0	0	374	0	11.00
13.00	01300	NURSING ADMINISTRATION	627	627	0	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	2,208	0	269	0	14.00
15.00	01500	PHARMACY	930	930	920	279	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	113	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,408	5,408	15,850	1,959	3,236	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,155	6,155	7,057	813	0	50.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	2,368	9,066	360	0	54.00
57.00	05700	CT SCAN	543	543	1,611	83	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,711	1,711	0	420	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	887	887	900	390	0	65.00
66.00	06600	PHYSICAL THERAPY	953	953	7,325	423	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239	239	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42	42	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	2,904	900	367	776	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,267	10,267	2,864	1,798	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	1,323	1,100	0	0	88.01
91.00	09100	EMERGENCY	2,225	2,225	26,406	2,505	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,756	45,127	73,999	10,153	4,012	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	6,745	3,177	708	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	586,801	441,746	99,116	411,090	174,378	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.862036	8.516078	1.284285	37.850106	43.464108	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,682	50,390	5,914	9,698	32,664	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.482042	0.971430	0.076630	0.892920	8.141575	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: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	9,143					11.00
13.00	01300	NURSING ADMINISTRATION	505	5,140				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	199	0	888,129			14.00
15.00	01500	PHARMACY	247	0	4,162	989,764		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	538	0	2,696	0	38,220,103	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,313	1,313	22,526	0	823,201	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	268	268	34,784	0	1,510,026	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,138	0	28,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	818	818	4,034	0	3,346,594	54.00
57.00	05700	CT SCAN	22	22	18,995	0	5,921,524	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,224	0	235,261	58.00
60.00	06000	LABORATORY	979	979	387,566	0	9,086,230	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	8	8	5,695	0	54,965	63.00
65.00	06500	RESPIRATORY THERAPY	382	382	13,050	0	1,689,896	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,656	0	1,374,082	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	343,898	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	60,344	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	296,520	0	490,698	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	989,764	3,994,881	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	266	266	1,327	0	680,174	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,081	0	25,648	0	2,950,889	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,510	0	200,789	88.01
91.00	09100	EMERGENCY	1,084	1,084	58,914	0	5,427,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,710	5,140	884,445	989,764	38,220,103	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	433	0	3,684	0	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
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)	306,914	804,113	193,026	434,701	447,319	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.568194	156.442218	0.217340	0.439197	0.011704	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,654	18,617	18,930	13,973	18,731	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.618397	3.621984	0.021314	0.014118	0.000490	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: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 11:55 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,043,043		2,043,043	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	705,588		705,588	0
53.00	05300	ANESTHESIOLOGY	10,682		10,682	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,150,688		1,150,688	0
57.00	05700	CT SCAN	524,177		524,177	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,528		70,528	0
60.00	06000	LABORATORY	2,014,399		2,014,399	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	43,817		43,817	0
65.00	06500	RESPIRATORY THERAPY	551,019	0	551,019	0
66.00	06600	PHYSICAL THERAPY	329,349	0	329,349	0
67.00	06700	OCCUPATIONAL THERAPY	103,271	0	103,271	0
68.00	06800	SPEECH PATHOLOGY	23,316	0	23,316	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,939		430,939	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,682,281		1,682,281	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	603,469		603,469	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,154,118		4,154,118	0
88.01	08801	RURAL HEALTH CLINIC II	390,852		390,852	0
91.00	09100	EMERGENCY	3,257,112		3,257,112	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	457,901		457,901	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	18,546,549	0	18,546,549	0
201.00		Less Observation Beds	457,901		457,901	0
202.00		Total (see instructions)	18,088,648	0	18,088,648	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 11:55 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	668,522		668,522			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,510,026	1,510,026	0.467269	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	28,698	28,698	0.372221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,906	3,303,688	3,346,594	0.343839	0.000000	54.00
57.00	05700	CT SCAN	193,113	5,728,411	5,921,524	0.088521	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	235,261	235,261	0.299786	0.000000	58.00
60.00	06000	LABORATORY	341,704	8,744,526	9,086,230	0.221698	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	8,500	46,465	54,965	0.797180	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	387,810	1,302,086	1,689,896	0.326067	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	216,601	1,157,481	1,374,082	0.239687	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,911	210,987	343,898	0.300295	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,333	47,011	60,344	0.386385	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,765	353,933	490,698	0.878216	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,735	3,655,146	3,994,881	0.421109	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	680,174	680,174	0.887227	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,950,889	2,950,889			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	200,789	200,789			88.01
91.00	09100	EMERGENCY	36,546	5,391,407	5,427,953	0.600063	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,325	150,354	154,679	2.960331	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,522,771	35,697,332	38,220,103			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,522,771	35,697,332	38,220,103			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1321		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part II Date/Time Prepared: 11/30/2020 11:55 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		128,118	1,510,026	0.084845	0	0	50.00
53.00	05300	ANESTHESIOLOGY		1,071	28,698	0.037320	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		193,009	3,346,594	0.057673	16,604	958	54.00
57.00	05700	CT SCAN		136,070	5,921,524	0.022979	103,105	2,369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		1,343	235,261	0.005709	0	0	58.00
60.00	06000	LABORATORY		106,573	9,086,230	0.011729	178,265	2,091	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		905	54,965	0.016465	5,609	92	63.00
65.00	06500	RESPIRATORY THERAPY		29,117	1,689,896	0.017230	235,055	4,050	65.00
66.00	06600	PHYSICAL THERAPY		12,850	1,374,082	0.009352	36,564	342	66.00
67.00	06700	OCCUPATIONAL THERAPY		3,453	343,898	0.010041	24,886	250	67.00
68.00	06800	SPEECH PATHOLOGY		699	60,344	0.011584	9,942	115	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		12,986	490,698	0.026464	71,441	1,891	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		37,319	3,994,881	0.009342	148,027	1,383	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		35,998	680,174	0.052925	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		147,623	2,950,889	0.050027	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		26,146	200,789	0.130216	0	0	88.01
91.00	09100	EMERGENCY		100,067	5,427,953	0.018435	1,726	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		33,665	154,679	0.217644	0	0	92.00
200.00		Total (lines 50 through 199)		1,007,012	37,551,581		831,224	13,573	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 11:55 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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,510,026	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	28,698	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,346,594	0.000000
57.00	05700	CT SCAN	0	0	0	5,921,524	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	235,261	0.000000
60.00	06000	LABORATORY	0	0	0	9,086,230	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	54,965	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,689,896	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,374,082	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	343,898	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	60,344	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	490,698	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,994,881	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	680,174	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,950,889	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	200,789	0.000000
91.00	09100	EMERGENCY	0	0	0	5,427,953	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	154,679	0.000000
200.00		Total (lines 50 through 199)	0	0	0	37,551,581	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	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	16,604	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	103,105	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	178,265	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	5,609	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	235,055	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	36,564	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,886	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,942	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71,441	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	148,027	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
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	1,726	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		831,224	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/30/2020 11:55 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	0.467269	0	917,431	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.372221	0	17,686	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.343839	0	1,156,917	0	0	54.00
57.00	05700	CT SCAN	0.088521	0	2,128,327	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.299786	0	105,559	0	0	58.00
60.00	06000	LABORATORY	0.221698	0	3,260,367	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.797180	0	25,005	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.326067	0	704,547	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.239687	0	429,843	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300295	0	25,452	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.386385	0	6,762	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.878216	0	204,860	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421109	0	2,217,303	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.887227	0	642,900	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.600063	0	1,746,825	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.960331	0	96,772	0	0	92.00
200.00		Subtotal (see instructions)		0	13,686,556	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,686,556	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/30/2020 11:55 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	428,687	0		50.00
53.00	05300	ANESTHESIOLOGY	6,583	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	397,793	0		54.00
57.00	05700	CT SCAN	188,402	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,645	0		58.00
60.00	06000	LABORATORY	722,817	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,933	0		63.00
65.00	06500	RESPIRATORY THERAPY	229,730	0		65.00
66.00	06600	PHYSICAL THERAPY	103,028	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,643	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,613	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,911	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	933,726	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	570,398	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	1,048,205	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	286,477	0		92.00
200.00		Subtotal (see instructions)	5,157,591	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,157,591	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 11:55 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)			747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			473	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)			306	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			206	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)			66	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			2	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)			244	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)			206	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)			64	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,043,043	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)			314	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)			746,116	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,296,927	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,296,927	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,741.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			669,028	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)			669,028	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 11:55 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						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)					281,663	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					950,691	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)					564,836	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					175,483	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					740,319	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)					167	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,741.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					457,901	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	150,204	2,043,043	0.073520	457,901	33,665	90.00
91.00	Nursing School cost	0	2,043,043	0.000000	457,901	0	91.00
92.00	Allied health cost	0	2,043,043	0.000000	457,901	0	92.00
93.00	All other Medical Education	0	2,043,043	0.000000	457,901	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 11:55 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		376,611		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.467269	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.372221	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343839	16,604	5,709	54.00
57.00	05700 CT SCAN	0.088521	103,105	9,127	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.299786	0	0	58.00
60.00	06000 LABORATORY	0.221698	178,265	39,521	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.797180	5,609	4,471	63.00
65.00	06500 RESPIRATORY THERAPY	0.326067	235,055	76,644	65.00
66.00	06600 PHYSICAL THERAPY	0.239687	36,564	8,764	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.300295	24,886	7,473	67.00
68.00	06800 SPEECH PATHOLOGY	0.386385	9,942	3,841	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.878216	71,441	62,741	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.421109	148,027	62,336	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.887227	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	0.600063	1,726	1,036	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.960331	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		831,224	281,663	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)		831,224		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321 Component CCN: 14-Z321	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 11:55 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.467269	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.372221	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343839	12,823	4,409	54.00
57.00	05700 CT SCAN	0.088521	14,883	1,317	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.299786	0	0	58.00
60.00	06000 LABORATORY	0.221698	77,102	17,093	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.797180	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.326067	94,690	30,875	65.00
66.00	06600 PHYSICAL THERAPY	0.239687	153,311	36,747	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.300295	94,082	28,252	67.00
68.00	06800 SPEECH PATHOLOGY	0.386385	3,391	1,310	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.878216	39,794	34,948	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.421109	129,808	54,663	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.887227	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	0.600063	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.960331	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		619,884	209,614	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)		619,884		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/30/2020 11:55 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,157,591
2.00	Medical and other services reimbursed under OPPS (see instructions)			0
3.00	OPPS payments			0
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,157,591
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			0
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
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
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			0
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			5,209,167
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			35,491
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,060,747
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,112,929
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			3,112,929
31.00	Primary payer payments			660
32.00	Subtotal (line 30 minus line 31)			3,112,269
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			628,915
35.00	Adjusted reimbursable bad debts (see instructions)			408,795
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			375,039
37.00	Subtotal (see instructions)			3,521,064
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			3,521,064
40.01	Sequestration adjustment (see instructions)			58,802
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			3,247,948
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			214,314
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/30/2020 11:55 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		723,614		2,598,573	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	02/05/2020	27,294	02/05/2020	149,943	3.01
3.02		06/04/2020	82,591	06/04/2020	499,432	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)		109,885		649,375	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)		833,499		3,247,948	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		71,760		214,314	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		905,259		3,462,262	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: 14-1321
 Component CCN: 14-Z321

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/30/2020 11:55 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		800,033		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/05/2020	19,212		0	3.01
3.02		06/04/2020	67,580		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)		86,792		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)		886,825		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		55,330		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		942,155		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/30/2020 11:55 am	
		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1321

Period:

Worksheet E-2

Component CCN: 14-Z321

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		747,722	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		211,710	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		270	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		959,432	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		959,432	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		959,432	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		2,728	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		956,704	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		2,234	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		1,452	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,354	0	18.00
19.00	Total (see instructions)		958,156	0	19.00
19.01	Sequestration adjustment (see instructions)		16,001	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		886,825	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		55,330	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1321	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/30/2020 11:55 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		950,691	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)		950,691	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		960,198	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)		960,198	19.00
20.00	Deductibles (exclude professional component)		72,132	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		888,066	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		888,066	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		50,104	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		32,568	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,232	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		920,634	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)		920,634	30.00
30.01	Sequestration adjustment (see instructions)		15,375	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		833,499	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)		71,760	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1321

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

Worksheet G

Date/Time Prepared:
11/30/2020 11:55 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	4,207,910	0	0	0	1.00
2.00	Temporary investments	3,969,172	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,975,635	0	0	0	4.00
5.00	Other receivable	1,002,081	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	327,431	0	0	0	7.00
8.00	Prepaid expenses	111,790	0	0	0	8.00
9.00	Other current assets	116,642	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,710,661	0	0	0	11.00
FIXED ASSETS						
12.00	Land	18,401	0	0	0	12.00
13.00	Land improvements	225,124	0	0	0	13.00
14.00	Accumulated depreciation	-131,191	0	0	0	14.00
15.00	Buildings	5,410,832	0	0	0	15.00
16.00	Accumulated depreciation	-4,474,847	0	0	0	16.00
17.00	Leasehold improvements	5,981,581	0	0	0	17.00
18.00	Accumulated depreciation	-4,801,603	0	0	0	18.00
19.00	Fixed equipment	11,625,913	0	0	0	19.00
20.00	Accumulated depreciation	-9,359,302	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	110,517	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,605,425	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,639,363	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,639,363	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,955,449	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,605,110	0	0	0	37.00
38.00	Salaries, wages, and fees payable	860,379	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	732,443	0	0	0	40.00
41.00	Deferred income	3,969,172	0	0	0	41.00
42.00	Accelerated payments	2,392,415	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,075,098	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,634,617	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,249,274	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)	6,249,274	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,883,891	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,071,558				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)	1,071,558	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,955,449	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1321

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

Worksheet G-1

Date/Time Prepared:
11/30/2020 11:55 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		1,521,126		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-449,568				2.00
3.00	Total (sum of line 1 and line 2)		1,071,558		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)		1,071,558		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)		1,071,558		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: 14-1321

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2020 11:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	506,232		506,232	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	161,105		161,105	5.00
6.00	Swing bed - NF	1,185		1,185	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	668,522		668,522	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	668,522		668,522	17.00
18.00	Ancillary services	1,813,378	27,003,893	28,817,271	18.00
19.00	Outpatient services	40,871	5,541,761	5,582,632	19.00
20.00	RURAL HEALTH CLINIC	0	2,950,889	2,950,889	20.00
20.01	RURAL HEALTH CLINIC II	0	200,789	200,789	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	105,933	347,407	453,340	27.00
27.01	SPECIALTY CLINIC	0	246,719	246,719	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,628,704	36,291,458	38,920,162	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,462,814		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	INTEREST EXPENSE	299,145			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)		299,145		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,163,669		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1321

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

Worksheet G-3

Date/Time Prepared:
11/30/2020 11:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,920,162	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,074,442	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,845,720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,163,669	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,317,949	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	50,625	6.00
7.00	Income from investments	24,923	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	5,342	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	101,091	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	2,741	17.00
18.00	Revenue from sale of medical records and abstracts	4,540	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	103,023	22.00
23.00	Governmental appropriations	949,533	23.00
24.00	340B RETAIL PHARMACY INCOME	698,357	24.00
24.01	NURSING HOME UTILITIES REIMBURSEMENT	84,286	24.01
24.02	MISCELLANEOUS INCOME	58,975	24.02
24.50	COVID-19 PHE Funding	84,090	24.50
25.00	Total other income (sum of lines 6-24)	2,167,526	25.00
26.00	Total (line 5 plus line 25)	-150,423	26.00
27.00	INTEREST EXPENSE	299,145	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	299,145	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-449,568	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	719,450	0	719,450	-13,819	705,631	1.00
2.00	Physician Assistant	73,731	0	73,731	-65	73,666	2.00
3.00	Nurse Practitioner	352,823	0	352,823	-5,604	347,219	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	470,054	0	470,054	0	470,054	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,616,058	0	1,616,058	-19,488	1,596,570	10.00
11.00	Physician Services Under Agreement	0	193,308	193,308	0	193,308	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	193,308	193,308	0	193,308	14.00
15.00	Medical Supplies	0	47,476	47,476	0	47,476	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,476	47,476	0	47,476	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,616,058	240,784	1,856,842	-19,488	1,837,354	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	19,488	19,488	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	19,488	19,488	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	84,564	84,564	0	84,564	29.00
30.00	Administrative Costs	409,061	268,093	677,154	-5,605	671,549	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	409,061	352,657	761,718	-5,605	756,113	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,025,119	593,441	2,618,560	-5,605	2,612,955	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	705,631	1.00	
2.00	Physician Assistant	0	73,666	2.00	
3.00	Nurse Practitioner	0	347,219	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	470,054	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	1,596,570	10.00	
11.00	Physician Services Under Agreement	0	193,308	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	193,308	14.00	
15.00	Medical Supplies	0	47,476	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	47,476	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,837,354	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	19,488	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	19,488	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	84,564	29.00	
30.00	Administrative Costs	0	671,549	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	756,113	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,612,955	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0 1.00
2.00	Physician Assistant	110,363	0	110,363	0	110,363 2.00
3.00	Nurse Practitioner	0	0	0	0	0 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	35,268	0	35,268	0	35,268 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	145,631	0	145,631	0	145,631 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	2,951	2,951	0	2,951 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,951	2,951	0	2,951 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	145,631	2,951	148,582	0	148,582 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	35,798	35,798	0	35,798 29.00
30.00	Administrative Costs	25,580	33,439	59,019	0	59,019 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,580	69,237	94,817	0	94,817 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	171,211	72,188	243,399	0	243,399 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	110,363	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	35,268	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	145,631	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	2,951	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,951	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	148,582	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	0	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	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	35,798	29.00
30.00	Administrative Costs	0	59,019	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	94,817	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	243,399	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-3469

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 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	3.12	9,702	4,200	13,104		1.00
2.00	Physician Assistant	0.50	1,126	2,100	1,050		2.00
3.00	Nurse Practitioner	3.05	6,754	2,100	6,405		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.67	17,582		20,559	20,559	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.67	17,582			20,559	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,837,354	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					19,488	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,856,842	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.989505	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					756,113	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,541,163	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,297,276	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,297,276	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,273,166	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,110,520	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-8510

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 11:55 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.00	12	4,200	0
2.00	Physician Assistant	0.88	1,248	2,100	1,848
3.00	Nurse Practitioner	0.00	0	2,100	0
4.00	Subtotal (sum of lines 1 through 3)	0.88	1,260		1,848
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.88	1,260		1,848
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				148,582
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				148,582
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				94,817
15.00	Parent provider overhead allocated to facility (see instructions)				147,453
16.00	Total overhead (sum of lines 14 and 15)				242,270
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				242,270
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				242,270
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				390,852

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/30/2020 11:55 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)			4,110,520	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,132	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,080,388	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,559	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)			20,559	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.47	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)			198.47	198.47	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	6,371	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	1,264,452	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,264,452	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,177,669	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				55,080	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				59,138	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.)				899,878	16.04
16.05	Total program cost (see instructions)			0	959,016	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				80,467	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				208,424	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				959,016	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21,851	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				980,867	22.00
23.00	Allowable bad debts (see instructions)				154,854	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				100,655	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				101,244	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				1,081,522	26.00
26.01	Sequestration adjustment (see instructions)				18,061	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				826,680	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)				236,781	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/30/2020 11:55 am		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			390,852	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,139	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			389,713	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,848	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)			1,848	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			210.88	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)			210.88	210.88	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	527	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	111,134	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	111,134	16.00
16.01	Total program charges (see instructions)(from contractor's records)				87,999	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				3,038	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				3,837	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.)				80,469	16.04
16.05	Total program cost (see instructions)			0	84,306	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				6,711	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				15,650	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				84,306	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				828	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				85,134	22.00
23.00	Allowable bad debts (see instructions)				5,454	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				3,545	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				2,860	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)				88,679	26.00
26.01	Sequestration adjustment (see instructions)				1,481	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				91,585	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)				-4,387	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: 14-1321 Component CCN: 14-3469	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/30/2020 11:55 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,596,570	1,596,570	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000129	0.000456	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		206	728	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,285	8,250	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,491	8,978	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,837,354	1,837,354	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,273,166	2,273,166	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002444	0.004886	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		5,556	11,107	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		10,047	20,085	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		68	241	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		147.75	83.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		52	170	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,683	14,168	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)			30,132	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)			21,851	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/30/2020 11:55 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		145,631	145,631	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000266	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	39	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	394	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	433	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		148,582	148,582	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		242,270	242,270	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.002914	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	706	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	1,139	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	11	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	103.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	8	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	828	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)			1,139	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)			828	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/30/2020 11:55 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		845,977	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		02/05/2020	19,297	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)		-19,297	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		826,680	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		236,781	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,063,461	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/30/2020 11:55 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		115,957	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		02/05/2020	24,372	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)		-24,372	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		91,585	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		4,387	6.02	
7.00	Total Medicare program liability (see instructions)		87,198	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00