

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: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/31/2020 4:16 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/31/2020	Time: 4:16 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 15101 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 MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2019 and ending 03/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) RICHARD GOINS

Officer or Administrator of Provider(s)

CEO

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	726,474	481,487	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	252,969	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC (MCC) I	0		193,590		0	10.00
10.01	RURAL HEALTH CLINIC (FCC) II	0		113,169		0	10.01
200.00	Total	0	979,443	788,246	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: 14-1323		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 4:16 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 28 CHICK STREET			PO Box:				1.00		
2.00	City: METROPOLIS			State: IL		Zip Code: 62960-		County: MASSAC 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF		MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	N	O N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC		MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O N	15.00
15.01	Hospital-Based Health Clinic - RHC II		MASSAC FAMILY CARE CLINIC	148598	99916		05/17/2019	N	O N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					04/01/2019	03/31/2020		20.00	
21.00	Type of Control (see instructions)					11			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 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 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 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: 14-1323		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 4:16 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
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Date/Time Prepared:
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	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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			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: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 4:16 pm	
			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.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 4:16 pm
		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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	107,124	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
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: 14-1323		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/31/2020 4:16 pm		
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:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	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	166.00		
								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: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/31/2020 4:16 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/31/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/26/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/31/2020 4:16 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	LEE		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/31/2020 4:16 pm

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRIN		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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	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	79,251.61	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	79,251.61	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	79,251.61	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 (MCC)	88.00				0	26.00
26.01 RURAL HEALTH CLINIC (FCC)	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,528	203	1,944			1.00
2.00	HMO and other (see instructions)	115	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	444	0	444			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		16	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,972	219	2,404			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,972	219	2,404	0.00	167.33	14.00
15.00	CAH visits	7,162	0	25,058			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 (MCC)	2,499	0	8,014	0.00	12.50	26.00
26.01	RURAL HEALTH CLINIC (FCC)	779	0	4,357	0.00	8.70	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	188.53	27.00
28.00	Observation Bed Days		0	311			28.00
29.00	Ambulance Trips	924					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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	377	60	510	1.00
2.00 HMO and other (see instructions)			29	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	377	60	510	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 (MCC)	0.00					26.00
26.01 RURAL HEALTH CLINIC (FCC)	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

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-3478		Period: From 04/01/2019 To 03/31/2020 Worksheet S-8 Date/Time Prepared: 8/31/2020 4:16 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	28 CHICK STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL 62960	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
		1.00	2.00	3.00	4.00
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
				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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		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	MASSAC		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	17:00	08:00	17:00	08:00
				17:00	11.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1323	Period: From 04/01/2019	Worksheet S-8
			Component CCN: 14-3478	To 03/31/2020	Date/Time Prepared: 8/31/2020 4:16 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:30		11.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-8598		Period: From 04/01/2019 To 03/31/2020 Worksheet S-8 Date/Time Prepared: 8/31/2020 4:16 pm	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	28 CHICK STREET			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS IL 62960			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	from
		1.00	2.00	3.00	4.00
		1.00		2.00	
11.00	Facility hours of operations (1)				11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			0 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.				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
		1.00		2.00	
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	MASSAC			2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		1.00		2.00	
11.00	Facility hours of operations (1)				11.00
		1.00		2.00	

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1323	Period: From 04/01/2019	Worksheet S-8
			Component CCN: 14-8598	To 03/31/2020	Date/Time Prepared: 8/31/2020 4:16 pm
			RHC II		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet S-10 Date/Time Prepared: 8/31/2020 4:16 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.500710		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,868,528		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		13,324,646		6.00
7.00	Medicaid cost (line 1 times line 6)		6,671,783		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,803,255		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,803,255		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)	107,798	0	107,798	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	53,976	0	53,976	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)	53,976	0	53,976	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)		814,058		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		529,137		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		814,058		27.01
28.00	Non-Medicare bad debt expense (see instructions)		0		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		284,921		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		338,897		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,142,152		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/31/2020 4:16 pm

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		668,383		270,393	938,776
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP		817,226		130,864	948,090
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,734,612		0	3,734,612
5.00	00500	ADMINISTRATIVE & GENERAL	1,391,597	2,964,696	4,356,293	-58,186	4,298,107
7.00	00700	OPERATION OF PLANT	243,946	972,485	1,216,431	-3,232	1,213,199
8.00	00800	LAUNDRY & LINEN SERVICE	13,187	122,595	135,782	0	135,782
9.00	00900	HOUSEKEEPING	298,815	103,232	402,047	0	402,047
10.00	01000	DIETARY	320,986	221,653	542,639	-302,293	240,346
11.00	01100	CAFETERIA	0	0	0	301,709	301,709
13.00	01300	NURSING ADMINISTRATION	238,321	25,410	263,731	-4,623	259,108
16.00	01600	MEDICAL RECORDS & LIBRARY	210,148	48,290	258,438	-3,232	255,206
17.00	01700	SOCIAL SERVICE	185,133	27,191	212,324	0	212,324
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	239,950	239,950
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,145,476	104,469	1,249,945	312,385	1,562,330
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	213,945	284,878	498,823	-127,389	371,434
53.00	05300	ANESTHESIOLOGY	0	246,867	246,867	-239,950	6,917
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,851	517,080	1,103,931	-23,122	1,080,809
60.00	06000	LABORATORY	628,197	895,416	1,523,613	-3,232	1,520,381
65.00	06500	RESPIRATORY THERAPY	348,686	55,357	404,043	-36,081	367,962
66.00	06600	PHYSICAL THERAPY	527,365	28,830	556,195	-3,232	552,963
69.00	06900	ELECTROCARDIOLOGY	93,549	241,947	335,496	26,701	362,197
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,966	8,311	60,277	67,353	127,630
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,709	15,709
73.00	07300	DRUGS CHARGED TO PATIENTS	384,039	562,375	946,414	59,619	1,006,033
76.00	03550	GERIATRIC PSYCH	239,743	126,197	365,940	-2,810	363,130
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	1,007,201	517,407	1,524,608	-349,654	1,174,954
88.01	08801	RURAL HEALTH CLINIC (FCC)	612,571	66,720	679,291	-24,331	654,960
90.00	09000	CLINIC	0	0	0	0	0
90.01	04951	WOUND CARE	0	95,098	95,098	-20	95,078
90.02	09002	CLINIC	88,057	9,591	97,648	0	97,648
91.00	09100	EMERGENCY	806,372	1,072,002	1,878,374	-22,355	1,856,019
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	16,418	16,418
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	466,662	86,895	553,557	-6,675	546,882
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		238,339	238,339	-238,339	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,102,813	14,863,552	24,966,365	-7,655	24,958,710
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,655	7,655
192.01	19201	FOUNDATION	0	2,092	2,092	0	2,092
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	10,102,813	14,865,644	24,968,457	0	24,968,457

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-133,508	805,268	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	-1,045	-1,045	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,470	944,620	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-230	3,734,382	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-75,000	4,223,107	5.00
7.00	00700	OPERATION OF PLANT	0	1,213,199	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,782	8.00
9.00	00900	HOUSEKEEPING	0	402,047	9.00
10.00	01000	DIETARY	0	240,346	10.00
11.00	01100	CAFETERIA	0	301,709	11.00
13.00	01300	NURSING ADMINISTRATION	0	259,108	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,247	253,959	16.00
17.00	01700	SOCIAL SERVICE	0	212,324	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	239,950	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-335,921	1,226,409	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	371,434	50.00
53.00	05300	ANESTHESIOLOGY	0	6,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,080,809	54.00
60.00	06000	LABORATORY	0	1,520,381	60.00
65.00	06500	RESPIRATORY THERAPY	0	367,962	65.00
66.00	06600	PHYSICAL THERAPY	0	552,963	66.00
69.00	06900	ELECTROCARDIOLOGY	-151,753	210,444	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,916	125,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,691	1,000,342	73.00
76.00	03550	GERIATRIC PSYCH	-1,670	361,460	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MCC)	-388	1,174,566	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	654,960	88.01
90.00	09000	CLINIC	0	0	90.00
90.01	04951	WOUND CARE	0	95,078	90.01
90.02	09002	CLINIC	0	97,648	90.02
91.00	09100	EMERGENCY	0	1,856,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	16,418	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	546,882	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-711,839	24,246,871	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,655	192.00
192.01	19201	FOUNDATION	0	2,092	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-711,839	24,256,618	200.00

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/31/2020 4:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	236,488		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,851		2.00
	TOTALS		0	238,339		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	178,469	123,240		1.00
	TOTALS		178,469	123,240		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	129,013		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	129,013		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	70,585		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	70,585		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	59,619		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	TOTALS		0	59,619		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,655		1.00
	TOTALS		0	7,655		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15,709		1.00
	TOTALS		0	15,709		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	26,701	0		1.00
	TOTALS		26,701	0		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,905		1.00
	TOTALS		0	33,905		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	335,921	0		1.00
	TOTALS		335,921	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICE	93.00	16,418	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		16,418	0		
	N - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	239,950		1.00
	TOTALS		0	239,950		
500.00	Grand Total: Increases		557,509	918,015		500.00

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/31/2020 4:16 pm

	Decreases						8/31/2020 4:16 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	238,339	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	238,339			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	178,469	123,240	0		1.00
	TOTALS		178,469	123,240			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,626	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,226	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,232	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	3,232	0		4.00
5.00	OPERATING ROOM	50.00	0	65,803	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,232	0		6.00
7.00	LABORATORY	60.00	0	3,232	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	6,832	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	3,232	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,232	0		10.00
11.00	GERIATRIC PSYCH	76.00	0	2,810	0		11.00
12.00	RURAL HEALTH CLINIC (MCC)	88.00	0	3,240	0		12.00
13.00	RURAL HEALTH CLINIC (FCC)	88.01	0	3,388	0		13.00
14.00	EMERGENCY	91.00	0	3,232	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	3,232	0		15.00
16.00	OPERATION OF PLANT	7.00	0	3,232	0		16.00
	TOTALS		0	129,013			
	D - MED SUPPLIES RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	63	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,834	0		2.00
3.00	OPERATING ROOM	50.00	0	45,561	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,548	0		4.00
5.00	RURAL HEALTH CLINIC (MCC)	88.00	0	550	0		5.00
6.00	EMERGENCY	91.00	0	17,915	0		6.00
7.00	AMBULANCE SERVICES	95.00	0	114	0		7.00
	TOTALS		0	70,585			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	584	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	3,397	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,078	0		3.00
4.00	OPERATING ROOM	50.00	0	316	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,827	0		5.00
6.00	WOUND CARE	90.01	0	20	0		6.00
7.00	RURAL HEALTH CLINIC (MCC)	88.00	0	9,943	0		7.00
8.00	RURAL HEALTH CLINIC (FCC)	88.01	0	20,943	0		8.00
9.00	EMERGENCY	91.00	0	182	0		9.00
10.00	AMBULANCE SERVICES	95.00	0	3,329	0		10.00
	TOTALS		0	59,619			
	F - POB REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,655	0		1.00
	TOTALS		0	7,655			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	15,709	0		1.00
	TOTALS		0	15,709			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	26,701	0	0		1.00
	TOTALS		26,701	0			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,905	12		1.00
	TOTALS		0	33,905			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC (MCC)	88.00	335,921	0	0		1.00
	TOTALS		335,921	0			
	M - BLOOD TRANSFUSION						
1.00	ADULTS & PEDIATRICS	30.00	15,392	0	0		1.00
2.00	EMERGENCY	91.00	1,026	0	0		2.00
	TOTALS		16,418	0			
	N - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	239,950	0		1.00
	TOTALS		0	239,950			
500.00	Grand Total: Decreases		557,509	918,015			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0	0	0	0	1.00	
2.00	Land Improvements	1,075,420	21,342	0	21,342	0	2.00	
3.00	Buildings and Fixtures	16,978,332	95,324	0	95,324	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	7,471,752	689,868	0	689,868	0	6.00	
7.00	HIT designated Assets	424,784	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	26,016,268	806,534	0	806,534	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	26,016,268	806,534	0	806,534	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0				1.00	
2.00	Land Improvements	1,096,762	0				2.00	
3.00	Buildings and Fixtures	17,073,656	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,161,620	0				6.00	
7.00	HIT designated Assets	424,784	0				7.00	
8.00	Subtotal (sum of lines 1-7)	26,822,802	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	26,822,802	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	666,359	2,024	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	817,226	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,483,585	2,024	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	668,383				1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	817,226				2.00
3.00	Total (sum of lines 1-2)	0	1,485,609				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	17,583,442	-53,822	17,637,264	0.700664	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,373,864	-161,073	7,534,937	0.299336	0	2.00
3.00	Total (sum of lines 1-2)	24,957,306	-214,895	25,172,201	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	666,359	2,024	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	813,756	129,013	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,480,115	131,037	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	102,980	33,905	0	0	805,268	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	-1,045	0	0	0	-1,045	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,851	0	0	0	944,620	2.00
3.00	Total (sum of lines 1-2)	103,786	33,905	0	0	1,748,843	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-133,508	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B					
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)	B	-1,045	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	11	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,206	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-487,674			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,247	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
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00			3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-12,052	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-25	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHARMACY REBATES	B	-5,691	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	OTHER REVENUE	B	-367	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER REVENUE	B	-24,562	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-1,916	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
42.00	LOBBYING EXPENSE	A	-2,478	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	RHC MISC INCOME	B	-388	RURAL HEALTH CLINIC (MCC)	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-1,670	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,540	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-882	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-230	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,930	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-29,428	ADMINISTRATIVE & GENERAL	5.00	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-711,839				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: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8-2

Date/Time Prepared:
8/31/2020 4:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	335,921	335,921	0	0	0	1.00
2.00	91.00	EMERGENCY	953,225	0	953,225	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	151,753	151,753	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,440,899	487,674	953,225		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	335,921		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	151,753		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	487,674		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
		0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	805,268	805,268			1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	-1,045	0	-1,045		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	944,620			944,620	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,734,382	3,725	0	4,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,223,107	186,445	0	201,752	5.00
7.00	00700	OPERATION OF PLANT	1,213,199	71,565	0	77,441	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	135,782	14,900	0	16,124	8.00
9.00	00900	HOUSEKEEPING	402,047	5,487	0	5,937	9.00
10.00	01000	DIETARY	240,346	17,937	0	19,410	10.00
11.00	01100	CAFETERIA	301,709	7,505	0	8,121	11.00
13.00	01300	NURSING ADMINISTRATION	259,108	3,119	0	3,376	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	253,959	14,120	0	17,186	16.00
17.00	01700	SOCIAL SERVICE	212,324	1,661	0	1,797	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	239,950	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,226,409	134,982	0	146,065	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	371,434	82,841	0	89,643	50.00
53.00	05300	ANESTHESIOLOGY	6,917	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,809	44,930	0	48,619	54.00
60.00	06000	LABORATORY	1,520,381	10,927	0	11,825	60.00
65.00	06500	RESPIRATORY THERAPY	367,962	15,111	0	16,352	65.00
66.00	06600	PHYSICAL THERAPY	552,963	31,810	0	34,421	66.00
69.00	06900	ELECTROCARDIOLOGY	210,444	28,002	0	30,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,714	12,680	0	13,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,709	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,000,342	5,230	0	5,659	73.00
76.00	03550	GERIATRIC PSYCH	361,460	13,239	0	14,327	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	1,174,566	17,084	0	58,200	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	654,960	13,762	0	14,892	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	95,078	12,845	0	13,900	90.01
90.02	09002	CLINIC	97,648	0	0	0	90.02
91.00	09100	EMERGENCY	1,856,019	53,820	0	58,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	16,418	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	546,882	0	0	31,314	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,246,871	803,727	0	942,952	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,541	0	1,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,655	0	0	0	192.00
192.01	19201	FOUNDATION	2,092	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	-1,045	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,256,618	805,268	-1,045	944,620	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,742,138					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	515,456	5,126,760	5,126,760			5.00
7.00	00700	OPERATION OF PLANT	90,359	1,452,564	389,262	1,841,826		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,885	171,691	46,010	50,491	268,192	8.00
9.00	00900	HOUSEKEEPING	110,683	524,154	140,464	18,592	0	9.00
10.00	01000	DIETARY	52,789	330,482	88,564	60,782	120	10.00
11.00	01100	CAFETERIA	66,106	383,441	102,756	25,432	0	11.00
13.00	01300	NURSING ADMINISTRATION	88,276	353,879	94,834	10,571	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,840	363,105	97,306	47,848	9,427	16.00
17.00	01700	SOCIAL SERVICE	68,574	284,356	76,203	5,627	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	239,950	64,303	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	543,013	2,050,469	549,491	457,401	60,284	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,247	623,165	166,998	280,715	2,653	50.00
53.00	05300	ANESTHESIOLOGY	0	6,917	1,854	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,373	1,391,731	372,960	152,250	10,200	54.00
60.00	06000	LABORATORY	232,688	1,775,821	475,890	37,029	0	60.00
65.00	06500	RESPIRATORY THERAPY	119,265	518,690	139,000	51,206	0	65.00
66.00	06600	PHYSICAL THERAPY	195,339	814,533	218,281	107,790	14,969	66.00
69.00	06900	ELECTROCARDIOLOGY	44,541	313,586	84,036	94,888	1,656	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,249	171,364	45,923	42,967	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,709	4,210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,250	1,153,481	309,113	17,722	6,346	73.00
76.00	03550	GERIATRIC PSYCH	88,802	477,828	128,050	44,863	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	248,646	1,498,496	401,571	57,890	69,647	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	226,900	910,514	244,002	46,636	56,978	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	121,823	32,646	43,527	0	90.01
90.02	09002	CLINIC	32,617	130,265	34,909	0	0	90.02
91.00	09100	EMERGENCY	298,305	2,266,384	607,354	182,376	35,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	6,081	22,499	6,029	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	172,854	751,050	201,269	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,742,138	24,244,707	5,123,288	1,836,603	267,971	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,209	860	5,223	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,655	2,051	0	221	192.00
192.01	19201	FOUNDATION	0	2,092	561	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	-1,045	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,742,138	24,256,618	5,126,760	1,841,826	268,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	683,210					9.00
10.00	01000	DIETARY	36,252	516,200				10.00
11.00	01100	CAFETERIA	0	236,037	747,666			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	25,032	484,316		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,449	0	40,582	0	567,717	16.00
17.00	01700	SOCIAL SERVICE	0	0	12,642	21,293	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	235,463	202,849	157,585	262,949	371,924	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	29,520	49,516	10,329	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,519	0	69,722	0	103,597	54.00
60.00	06000	LABORATORY	30,864	0	97,093	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,633	0	46,587	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,225	0	49,242	0	25,784	66.00
69.00	06900	ELECTROCARDIOLOGY	872	0	6,764	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	12,579	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,468	0	29,709	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	26,342	26,486	40,176	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	66,978	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	62,011	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	120,049	0	81,480	110,382	56,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	603,772	465,228	747,034	484,316	567,717	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,438	50,972	632	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	683,210	516,200	747,666	484,316	567,717	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	400,121					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		304,253				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	400,121	0	4,748,536	0	4,748,536	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,162,896	0	1,162,896	50.00
53.00	05300	ANESTHESIOLOGY	0	304,253	313,024	0	313,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,158,979	0	2,158,979	54.00
60.00	06000	LABORATORY	0	0	2,416,697	0	2,416,697	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	777,116	0	777,116	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,248,824	0	1,248,824	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	501,802	0	501,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	272,833	0	272,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,919	0	19,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,521,839	0	1,521,839	73.00
76.00	03550	GERIATRIC PSYCH	0	0	743,745	0	743,745	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	2,094,582	0	2,094,582	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	1,320,141	0	1,320,141	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	197,996	0	197,996	90.01
90.02	09002	CLINIC	0	0	165,174	0	165,174	90.02
91.00	09100	EMERGENCY	0	0	3,459,799	0	3,459,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	28,528	0	28,528	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	952,319	0	952,319	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,121	304,253	24,104,749	0	24,104,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,292	0	9,292	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	140,969	0	140,969	192.00
192.01	19201	FOUNDATION	0	0	2,653	0	2,653	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	-1,045	0	-1,045	201.00
202.00		TOTAL (sum lines 118 through 201)	400,121	304,253	24,256,618	0	24,256,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,725	0	0	4,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	186,445	0	0	201,752	5.00
7.00	00700	OPERATION OF PLANT	0	71,565	0	0	77,441	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,900	0	0	16,124	8.00
9.00	00900	HOUSEKEEPING	0	5,487	0	0	5,937	9.00
10.00	01000	DIETARY	0	17,937	0	0	19,410	10.00
11.00	01100	CAFETERIA	0	7,505	0	0	8,121	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,119	0	0	3,376	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,120	0	0	17,186	16.00
17.00	01700	SOCIAL SERVICE	0	1,661	0	0	1,797	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	134,982	0	0	146,065	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	82,841	0	0	89,643	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,930	0	0	48,619	54.00
60.00	06000	LABORATORY	0	10,927	0	0	11,825	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,111	0	0	16,352	65.00
66.00	06600	PHYSICAL THERAPY	0	31,810	0	0	34,421	66.00
69.00	06900	ELECTROCARDIOLOGY	0	28,002	0	0	30,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,680	0	0	13,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,230	0	0	5,659	73.00
76.00	03550	GERIATRIC PSYCH	0	13,239	0	0	14,327	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	17,084	0	0	58,200	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	13,762	0	0	14,892	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	12,845	0	0	13,900	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	53,820	0	0	58,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	31,314	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	803,727	0	0	942,952	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,541	0	0	1,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	-1,045	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	805,268	-1,045	0	944,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,756	7,756			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	388,197	1,069	389,266		5.00
7.00	00700	OPERATION OF PLANT	149,006	187	29,555	178,748	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,024	10	3,493	4,900	8.00
9.00	00900	HOUSEKEEPING	11,424	229	10,665	1,804	9.00
10.00	01000	DIETARY	37,347	109	6,724	5,899	10.00
11.00	01100	CAFETERIA	15,626	137	7,802	2,468	11.00
13.00	01300	NURSING ADMINISTRATION	6,495	183	7,200	1,026	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,306	161	7,388	4,644	16.00
17.00	01700	SOCIAL SERVICE	3,458	142	5,786	546	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,882	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	281,047	1,125	41,721	44,391	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	172,484	164	12,680	27,243	50.00
53.00	05300	ANESTHESIOLOGY	0	0	141	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,549	451	28,318	14,776	54.00
60.00	06000	LABORATORY	22,752	482	36,133	3,594	60.00
65.00	06500	RESPIRATORY THERAPY	31,463	247	10,554	4,969	65.00
66.00	06600	PHYSICAL THERAPY	66,231	405	16,573	10,461	66.00
69.00	06900	ELECTROCARDIOLOGY	58,601	92	6,381	9,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,401	40	3,487	4,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	320	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,889	295	23,470	1,720	73.00
76.00	03550	GERIATRIC PSYCH	27,566	184	9,722	4,354	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	75,284	516	30,490	5,618	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	28,654	470	18,526	4,526	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	26,745	0	2,479	4,224	90.01
90.02	09002	CLINIC	0	68	2,651	0	90.02
91.00	09100	EMERGENCY	112,060	619	46,121	17,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	13	458	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	31,314	358	15,282	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,746,679	7,756	389,002	178,241	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,209	0	65	507	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	156	0	192.00
192.01	19201	FOUNDATION	0	0	43	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0				200.00
201.00		Negative Cost Centers	-1,045	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,748,843	7,756	389,266	178,748	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	24,122					9.00
10.00	01000	DIETARY	1,280	51,377				10.00
11.00	01100	CAFETERIA	0	23,493	49,526			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,658	16,562		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	334	0	2,688	0	47,907	16.00
17.00	01700	SOCIAL SERVICE	0	0	837	728	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,312	20,189	10,440	8,992	31,384	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,955	1,693	872	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,066	0	4,618	0	8,742	54.00
60.00	06000	LABORATORY	1,090	0	6,432	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	764	0	3,086	0	0	65.00
66.00	06600	PHYSICAL THERAPY	643	0	3,262	0	2,176	66.00
69.00	06900	ELECTROCARDIOLOGY	31	0	448	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	833	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193	0	1,968	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	2,622	1,754	1,374	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	2,365	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	4,108	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,239	0	5,397	3,775	4,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,317	46,304	49,484	16,562	47,907	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,805	5,073	42	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	24,122	51,377	49,526	16,562	47,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	11,497					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	4,882				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,497		467,960	0	467,960	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		217,481	0	217,481	50.00
53.00	05300	ANESTHESIOLOGY	0		141	0	141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		154,019	0	154,019	54.00
60.00	06000	LABORATORY	0		70,483	0	70,483	60.00
65.00	06500	RESPIRATORY THERAPY	0		51,083	0	51,083	65.00
66.00	06600	PHYSICAL THERAPY	0		101,952	0	101,952	66.00
69.00	06900	ELECTROCARDIOLOGY	0		75,005	0	75,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		34,931	0	34,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		320	0	320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		39,468	0	39,468	73.00
76.00	03550	GERIATRIC PSYCH	0		47,576	0	47,576	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	0		124,513	0	124,513	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0		64,660	0	64,660	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		33,448	0	33,448	90.01
90.02	09002	CLINIC	0		2,719	0	2,719	90.02
91.00	09100	EMERGENCY	0		199,890	0	199,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0		471	0	471	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		46,954	0	46,954	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,497	0	1,733,074	0	1,733,074	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		3,781	0	3,781	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		8,108	0	8,108	192.00
192.01	19201	FOUNDATION	0		43	0	43	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		4,882	4,882	0	4,882	200.00
201.00		Negative Cost Centers	0	0	-1,045	0	-1,045	201.00
202.00		TOTAL (sum lines 118 through 201)	11,497	4,882	1,748,843	0	1,748,843	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,768					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				95,144		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	10,102,813	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,321	0	0	20,321	1,391,597	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	243,946	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	13,187	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	298,815	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	142,517	10.00
11.00	01100	CAFETERIA	818	0	0	818	178,469	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	238,321	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	210,148	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	185,133	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,466,005	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	213,945	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	586,851	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	628,197	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	321,985	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	527,365	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	120,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	51,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	384,039	73.00
76.00	03550	GERIATRIC PSYCH	1,443	0	0	1,443	239,743	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	1,862	0	0	5,862	671,280	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,500	0	0	1,500	612,571	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	1,400	0	90.01
90.02	09002	CLINIC	0	0	0	0	88,057	90.02
91.00	09100	EMERGENCY	5,866	0	0	5,866	805,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	16,418	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	466,662	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,600	0	0	94,976	10,102,813	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	805,268	-1,045	0	944,620	3,742,138	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.174961	0.000000	0.000000	9.928319	0.370406	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					7,756	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000768	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,126,760	19,130,903			5.00
7.00	00700	OPERATION OF PLANT	0	1,452,564	59,241		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,691	1,624	58,319	8.00
9.00	00900	HOUSEKEEPING	0	524,154	598	0	9.00
10.00	01000	DIETARY	0	330,482	1,955	26	10.00
11.00	01100	CAFETERIA	0	383,441	818	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	353,879	340	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	363,105	1,539	2,050	16.00
17.00	01700	SOCIAL SERVICE	0	284,356	181	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	239,950	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,050,469	14,712	13,109	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	623,165	9,029	577	50.00
53.00	05300	ANESTHESIOLOGY	0	6,917	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,391,731	4,897	2,218	54.00
60.00	06000	LABORATORY	0	1,775,821	1,191	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	518,690	1,647	0	65.00
66.00	06600	PHYSICAL THERAPY	0	814,533	3,467	3,255	66.00
69.00	06900	ELECTROCARDIOLOGY	0	313,586	3,052	360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	171,364	1,382	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,153,481	570	1,380	73.00
76.00	03550	GERIATRIC PSYCH	0	477,828	1,443	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	1,498,496	1,862	15,145	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	910,514	1,500	12,390	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	121,823	1,400	0	90.01
90.02	09002	CLINIC	0	130,265	0	0	90.02
91.00	09100	EMERGENCY	0	2,266,384	5,866	7,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	22,499	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	751,050	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,126,760	19,117,947	59,073	58,271	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,209	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,655	0	48	192.00
192.01	19201	FOUNDATION	0	2,092	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
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)		5,126,760	1,841,826	268,192	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.267983	31.090393	4.598707	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		389,266	178,748	39,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.020347	3.017302	0.676058	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNED TI MES)	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE					1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG					1.02
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
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	39,212				10.00
11.00	01100	CAFETERIA	17,930	11,828			11.00
13.00	01300	NURSING ADMINISTRATION	0	396	4,822		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	642	0	185,500	16.00
17.00	01700	SOCIAL SERVICE	0	200	212	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,409	2,493	2,618	121,525	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	467	493	3,375	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,103	0	33,850	54.00
60.00	06000	LABORATORY	0	1,536	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	737	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	779	0	8,425	66.00
69.00	06900	ELECTROCARDIOLOGY	0	107	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	470	0	0	73.00
76.00	03550	GERIATRIC PSYCH	2,001	419	400	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	981	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,289	1,099	18,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,340	11,818	4,822	185,500	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,872	10	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
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)	516,200	747,666	484,316	567,717	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.164337	63.211532	100.438822	3.060469	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,377	49,526	16,562	47,907	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.310237	4.187183	3.434674	0.258259	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	1.02
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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	GERIATRIC PSYCH	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (MCC)	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	88.01
90.00	09000	CLINIC	90.00
90.01	04951	WOUND CARE	90.01
90.02	09002	CLINIC	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FOUNDATION	192.01
193.00	19300	NONPAID WORKERS	193.00
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-2

Date/Time Prepared:
8/31/2020 4:16 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,748,536		4,748,536	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,162,896		1,162,896	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	313,024		313,024	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,158,979		2,158,979	0	0	54.00	
60.00	06000	LABORATORY	2,416,697		2,416,697	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	777,116	0	777,116	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,248,824	0	1,248,824	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	501,802		501,802	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	272,833		272,833	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,919		19,919	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,521,839		1,521,839	0	0	73.00	
76.00	03550	GERIATRIC PSYCH	743,745		743,745	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC (MCC)	2,094,582		2,094,582	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,320,141		1,320,141	0	0	88.01	
90.00	09000	CLINIC	0		0	0	0	90.00	
90.01	04951	WOUND CARE	197,996		197,996	0	0	90.01	
90.02	09002	CLINIC	165,174		165,174	0	0	90.02	
91.00	09100	EMERGENCY	3,459,799		3,459,799	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	546,918		546,918	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE	28,528		28,528	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	952,319		952,319	0	0	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	24,651,667	0	24,651,667	0	0	200.00	
201.00		Less Observation Beds	546,918		546,918			201.00	
202.00		Total (see instructions)	24,104,749	0	24,104,749	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet C Part I Date/Time Prepared: 8/31/2020 4:16 pm	
					Title XVIII		Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,269,800		2,269,800			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,185,672	2,185,672	0.532054	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	456,348	456,348	0.685933	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,534,179	16,324,534	17,858,713	0.120892	0.000000	54.00
60.00	06000	LABORATORY	1,080,868	5,607,242	6,688,110	0.361342	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	992,489	449,627	1,442,116	0.538872	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	312,799	1,366,929	1,679,728	0.743468	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	762,846	2,121,455	2,884,301	0.173977	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,697	56,669	64,366	4.238775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,563	23,563	0.845351	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	984,084	1,353,547	2,337,631	0.651018	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	261	908,852	909,113	0.818100	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	731,869	731,869			88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	493,417	493,417			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	0	174,292	174,292	1.136002	0.000000	90.01
90.02	09002	CLINIC	0	70,929	70,929	2.328723	0.000000	90.02
91.00	09100	EMERGENCY	351,758	4,984,866	5,336,624	0.648312	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,317	193,578	195,895	2.791894	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	69,840	69,840	0.408477	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,268,795	2,268,795	0.419747	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,299,098	39,842,024	48,141,122			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,299,098	39,842,024	48,141,122			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 GERIATRIC PSYCH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MCC)				88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)				88.01
90.00	09000 CLINIC	0.000000			90.00
90.01	04951 WOUND CARE	0.000000			90.01
90.02	09002 CLINIC	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	217,481	2,185,672	0.099503	0	0	50.00
53.00	05300 ANESTHESIOLOGY	141	456,348	0.000309	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	154,019	17,858,713	0.008624	619,288	5,341	54.00
60.00	06000 LABORATORY	70,483	6,688,110	0.010539	730,006	7,694	60.00
65.00	06500 RESPIRATORY THERAPY	51,083	1,442,116	0.035422	618,148	21,896	65.00
66.00	06600 PHYSICAL THERAPY	101,952	1,679,728	0.060696	97,347	5,909	66.00
69.00	06900 ELECTROCARDIOLOGY	75,005	2,884,301	0.026005	337,242	8,770	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34,931	64,366	0.542693	4,158	2,257	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	320	23,563	0.013581	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,468	2,337,631	0.016884	660,352	11,149	73.00
76.00	03550 GERIATRIC PSYCH	47,576	909,113	0.052332	261	14	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (MCC)	124,513	731,869	0.170130	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	64,660	493,417	0.131045	0	0	88.01
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	04951 WOUND CARE	33,448	174,292	0.191908	0	0	90.01
90.02	09002 CLINIC	2,719	70,929	0.038334	0	0	90.02
91.00	09100 EMERGENCY	199,890	5,336,624	0.037456	53,303	1,997	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	53,898	195,895	0.275137	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	471	69,840	0.006744	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,272,058	43,602,527		3,120,105	65,027	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1323		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/31/2020 4:16 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	304,253	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	304,253	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,185,672	0.000000
53.00	05300	ANESTHESIOLOGY	0	304,253	0	456,348	0.666713
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,858,713	0.000000
60.00	06000	LABORATORY	0	0	0	6,688,110	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,442,116	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,679,728	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,884,301	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	64,366	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,563	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,337,631	0.000000
76.00	03550	GERIATRIC PSYCH	0	0	0	909,113	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	0	731,869	0.000000
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	493,417	0.000000
90.00	09000	CLINIC	0	0	0	0	0.000000
90.01	04951	WOUND CARE	0	0	0	174,292	0.000000
90.02	09002	CLINIC	0	0	0	70,929	0.000000
91.00	09100	EMERGENCY	0	0	0	5,336,624	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	195,895	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	69,840	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	304,253	0	43,602,527	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	619,288	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	730,006	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	618,148	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	97,347	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	337,242	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,158	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	660,352	0	0	0	73.00
76.00	03550 GERIATRIC PSYCH	0.000000	261	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (MCC)	0.000000	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04951 WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	0	0	90.02
91.00	09100 EMERGENCY	0.000000	53,303	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		3,120,105	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/31/2020 4:16 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.532054	0	778,223	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.685933	0	190,616	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120892	0	6,438,767	0	0	54.00
60.00	06000	LABORATORY	0.361342	0	1,981,447	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.538872	0	89,733	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743468	0	506,069	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.173977	0	966,132	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.238775	0	29,655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.845351	0	23,563	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.651018	0	926,935	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.818100	0	791,030	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000				0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	1.136002	0	145,220	0	0	90.01
90.02	09002	CLINIC	2.328723	0	27,681	0	0	90.02
91.00	09100	EMERGENCY	0.648312	0	1,710,677	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.791894	0	167,907	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.408477	0	60,000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.419747		0			95.00
200.00		Subtotal (see instructions)		0	14,833,655	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	14,833,655	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/31/2020 4:16 pm

				Title XVIII	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	414,057	0		50.00
53.00	05300	ANESTHESIOLOGY	130,750	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	778,395	0		54.00
60.00	06000	LABORATORY	715,980	0		60.00
65.00	06500	RESPIRATORY THERAPY	48,355	0		65.00
66.00	06600	PHYSICAL THERAPY	376,246	0		66.00
69.00	06900	ELECTROCARDIOLOGY	168,085	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,701	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,919	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,451	0		73.00
76.00	03550	GERIATRIC PSYCH	647,142	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	04951	WOUND CARE	164,970	0		90.01
90.02	09002	CLINIC	64,461	0		90.02
91.00	09100	EMERGENCY	1,109,052	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	468,779	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	24,509	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,859,852	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,859,852	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

From 04/01/2019

To 03/31/2020

Worksheet D

Part IV

Date/Time Prepared:

8/31/2020 4:16 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	304,253	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	304,253	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2019
To 03/31/2020

Part IV
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description			Title XVIII		Swing Beds - SNF	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	2,185,672	0.000000
53.00	05300	ANESTHESIOLOGY	0	304,253	0	456,348	0.666713
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,858,713	0.000000
60.00	06000	LABORATORY	0	0	0	6,688,110	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,442,116	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,679,728	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,884,301	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	64,366	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,563	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,337,631	0.000000
76.00	03550	GERIATRIC PSYCH	0	0	0	909,113	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0	0	731,869	0.000000
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	493,417	0.000000
90.00	09000	CLINIC	0	0	0	0	0.000000
90.01	04951	WOUND CARE	0	0	0	174,292	0.000000
90.02	09002	CLINIC	0	0	0	70,929	0.000000
91.00	09100	EMERGENCY	0	0	0	5,336,624	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	195,895	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	69,840	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	304,253	0	43,602,527	0.000000

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2019
To 03/31/2020

Part IV
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		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	38,230	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	74,236	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	135,796	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	185,235	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,842	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,659	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	150,010	0	0	0	73.00
76.00	03550 GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (MCC)	0.000000	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04951 WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		590,008	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
8/31/2020 4:16 pm

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.532054	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.685933	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120892	0	0	0	54.00
60.00	06000	LABORATORY	0.361342	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.538872	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743468	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.173977	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.238775	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.845351	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.651018	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.818100	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MCC)	0.000000			0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000			0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	04951	WOUND CARE	1.136002	0	0	0	90.01
90.02	09002	CLINIC	2.328723	0	0	0	90.02
91.00	09100	EMERGENCY	0.648312	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.791894	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.408477	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.419747		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
8/31/2020 4:16 pm

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	GERIATRIC PSYCH	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (MCC)	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/31/2020 4:16 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,715	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,255	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,944	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			243	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)			201	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			16	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)			1,528	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)			243	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)			201	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			132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,748,536	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)			2,122	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)			782,932	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,965,604	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,965,604	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,758.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,687,110	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)			2,687,110	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					1,285,095	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,972,205	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)					427,335	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					353,475	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					780,810	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)					311	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,758.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					546,918	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/31/2020 4:16 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	467,960	4,748,536	0.098548	546,918	53,898	90.00
91.00	Nursing School cost	0	4,748,536	0.000000	546,918	0	91.00
92.00	Allied health cost	0	4,748,536	0.000000	546,918	0	92.00
93.00	All other Medical Education	0	4,748,536	0.000000	546,918	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/31/2020 4:16 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,645,990		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.532054	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.685933	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.120892	619,288	74,867	54.00
60.00	06000 LABORATORY	0.361342	730,006	263,782	60.00
65.00	06500 RESPIRATORY THERAPY	0.538872	618,148	333,103	65.00
66.00	06600 PHYSICAL THERAPY	0.743468	97,347	72,374	66.00
69.00	06900 ELECTROCARDIOLOGY	0.173977	337,242	58,672	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4.238775	4,158	17,625	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.845351	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.651018	660,352	429,901	73.00
76.00	03550 GERIATRIC PSYCH	0.818100	261	214	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MCC)	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04951 WOUND CARE	1.136002	0	0	90.01
90.02	09002 CLINIC	2.328723	0	0	90.02
91.00	09100 EMERGENCY	0.648312	53,303	34,557	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.791894	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.408477	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,120,105	1,285,095	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,120,105		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323 Component CCN: 14-Z323	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/31/2020 4:16 pm	
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	0.532054	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.685933	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.120892	38,230	4,622	54.00
60.00	06000 LABORATORY	0.361342	74,236	26,825	60.00
65.00	06500 RESPIRATORY THERAPY	0.538872	135,796	73,177	65.00
66.00	06600 PHYSICAL THERAPY	0.743468	185,235	137,716	66.00
69.00	06900 ELECTROCARDIOLOGY	0.173977	4,842	842	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4.238775	1,659	7,032	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.845351	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.651018	150,010	97,659	73.00
76.00	03550 GERIATRIC PSYCH	0.818100	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC (MCC)	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04951 WOUND CARE	1.136002	0	0	90.01
90.02	09002 CLINIC	2.328723	0	0	90.02
91.00	09100 EMERGENCY	0.648312	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.791894	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.408477	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		590,008	347,873	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		590,008		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/31/2020 4:16 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,859,852 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,859,852 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			5,918,451 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			51,608 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,475,523 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,391,320 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,391,320 30.00
31.00	Primary payer payments			37 31.00
32.00	Subtotal (line 30 minus line 31)			3,391,283 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			681,282 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			442,833 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			533,833 36.00
37.00	Subtotal (see instructions)			3,834,116 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,834,116 40.00
40.01	Sequestration adjustment (see instructions)			76,682 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,275,947 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			481,487 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/31/2020 4:16 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,816,952		2,726,323	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	10/30/2019	75,843	10/30/2019	456,694	3.01
3.02		03/26/2020	9,019	03/26/2020	92,930	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)		84,862		549,624	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,901,814		3,275,947	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		726,474		481,487	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,628,288		3,757,434	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323

Period:

Worksheet E-1

Component CCN: 14-Z323

From 04/01/2019
To 03/31/2020Part I
Date/Time Prepared:
8/31/2020 4:16 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		923,725		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	10/30/2019	47,054		0	3.50
3.51		03/26/2020	18,884		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)		-65,938		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)		857,787		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		252,969		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,110,756		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/31/2020 4:16 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1323 Component CCN: 14-Z323	Period: From 04/01/2019 To 03/31/2020	Worksheet E-2 Date/Time Prepared: 8/31/2020 4:16 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	788,618	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)	351,352	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	444	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,139,970	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,139,970	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,139,970	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,545	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,133,425	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,133,425	0	19.00
19.01	Sequestration adjustment (see instructions)	22,669	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	857,787	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)	252,969	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: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/31/2020 4:16 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,972,205	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)		3,972,205	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,011,927	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)		4,011,927	19.00
20.00	Deductibles (exclude professional component)		387,603	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,624,324	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,624,324	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		120,017	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		78,011	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		78,135	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,702,335	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)		3,702,335	30.00
30.01	Sequestration adjustment (see instructions)		74,047	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		2,901,814	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)		726,474	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: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet G

Date/Time Prepared:
8/31/2020 4:16 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	19,897,285	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,383,306	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,917,246	0	0	0	6.00
7.00	Inventory	423,074	0	0	0	7.00
8.00	Prepaid expenses	439,963	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,226,382	0	0	0	11.00
FIXED ASSETS						
12.00	Land	227,659	0	0	0	12.00
13.00	Land improvements	1,099,097	0	0	0	13.00
14.00	Accumulated depreciation	-878,966	0	0	0	14.00
15.00	Buildings	18,111,238	0	0	0	15.00
16.00	Accumulated depreciation	-9,856,791	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,618,375	0	0	0	23.00
24.00	Accumulated depreciation	-7,291,817	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,028,795	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	433,414	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	433,414	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,688,591	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	581,776	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,315,775	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	589,026	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,486,577	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,310,590	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	242,145	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,552,735	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,039,312	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,649,279				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)	24,649,279	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,688,591	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-1

Date/Time Prepared:
8/31/2020 4:16 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,608,912		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-565,600				2.00
3.00	Total (sum of line 1 and line 2)		22,043,312		0		3.00
4.00	NON OPERATING EQUITY ADJ	2,605,967		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)		2,605,967		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,649,279		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)		24,649,279		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	NON OPERATING EQUITY ADJ		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: 14-1323

Period:
From 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/31/2020 4:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,821,750		2,821,750	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	179,196		179,196	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,000,946		3,000,946	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)	3,000,946		3,000,946	17.00
18.00	Ancillary services	5,008,572	37,334,445	42,343,017	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (MCC)	0	731,869	731,869	20.00
20.01	RURAL HEALTH CLINIC (FCC)	0	493,417	493,417	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,268,795	2,268,795	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,009,518	40,828,526	48,838,044	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,968,457		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,968,457		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-3

Date/Time Prepared:
8/31/2020 4:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,838,044	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,957,818	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,880,226	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,968,457	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,088,231	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	522,631	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	0	24.00
25.00	Total other income (sum of lines 6-24)	522,631	25.00
26.00	Total (line 5 plus line 25)	-565,600	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-565,600	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/31/2020 4:16 pm

						RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification 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	457,627	0	457,627	0	457,627	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	107,079	0	107,079	0	107,079	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	0	0	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)	564,706	0	564,706	0	564,706	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	0	0	0	0	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	25,372	25,372	0	25,372	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	25,372	25,372	0	25,372	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	564,706	25,372	590,078	0	590,078	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						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	23,810	23,810	0	23,810	29.00		
30.00	Administrative Costs	318,133	242,545	560,678	0	560,678	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	318,133	266,355	584,488	0	584,488	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	882,839	291,727	1,174,566	0	1,174,566	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/31/2020 4:16 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	457,627		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	107,079		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	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	564,706		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	0		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	25,372		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	25,372		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	590,078		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	23,810		29.00
30.00	Administrative Costs	0	560,678		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	584,488		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,174,566		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8598

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/31/2020 4:16 pm

				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	203,069	0	203,069	0	203,069	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	134,765	0	134,765	0	134,765	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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)	337,834	0	337,834	0	337,834	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	16,824	16,824	0	16,824	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,824	16,824	0	16,824	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	337,834	16,824	354,658	0	354,658	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						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	2,962	2,962	0	2,962	29.00
30.00	Administrative Costs	274,737	22,603	297,340	0	297,340	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	274,737	25,565	300,302	0	300,302	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	612,571	42,389	654,960	0	654,960	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-8598

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/31/2020 4:16 pm

				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	203,069	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	134,765	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	0	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	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	337,834	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00	
15.00	Medical Supplies	0	16,824	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	16,824	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	354,658	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			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	2,962	29.00	
30.00	Administrative Costs	0	297,340	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	300,302	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	654,960	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-3478

From 04/01/2019

Date/Time Prepared:

To 03/31/2020

8/31/2020 4:16 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.34	5,434	4,200	5,628		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.72	2,580	2,100	1,512		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.06	8,014		7,140	8,014	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.06	8,014			8,014	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)					590,078	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					590,078	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					584,488	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					920,016	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,504,504	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,504,504	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,504,504	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,094,582	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-8598

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/31/2020 4:16 pm

		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	0.63	3,172	4,200	2,646	1.00
2.00	Physician Assistant	0.00	0	0	0	2.00
3.00	Nurse Practitioner	0.96	1,185	2,100	2,016	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	4,357	4,662	4,662	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)	1.59	4,357		4,662	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)				354,658	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				354,658	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				300,302	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				665,181	15.00
16.00	Total overhead (sum of lines 14 and 15)				965,483	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				965,483	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				965,483	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,320,141	20.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3	
		Component CCN: 14-3478		Date/Time Prepared: 8/31/2020 4:16 pm	
		Title XVIII	RHC I	Cost	
			1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,094,582	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			14,244	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,080,338	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,014	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)			8,014	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			259.59	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		259.59	259.59	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,499	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	648,715	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	648,715	16.00
16.01	Total program charges (see instructions)(from contractor's records)			229,081	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			501,592	16.04
16.05	Total program cost (see instructions)		0	501,592	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			21,725	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			41,470	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			501,592	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,105	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			511,697	22.00
23.00	Allowable bad debts (see instructions)			12,759	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			8,293	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,593	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)			519,990	26.00
26.01	Sequestration adjustment (see instructions)			10,400	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			316,000	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)			193,590	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		MASSAC MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 8/31/2020 4:16 pm	
		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)			1,320,141 1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,276 2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,310,865 3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,662 4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0 5.00	
6.00	Total adjusted visits (line 4 plus line 5)			4,662 6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			281.18 7.00	
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		281.18	281.18	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	779	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	219,039	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	219,039	16.00
16.01	Total program charges (see instructions)(from contractor's records)			80,468	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			169,436	16.04
16.05	Total program cost (see instructions)		0	169,436	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,244	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			14,618	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			169,436	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			5,621	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			175,057	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			175,057	26.00
26.01	Sequestration adjustment (see instructions)			3,501	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			58,387	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)			113,169	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: 14-1323 Component CCN: 14-3478	Period: From 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 8/31/2020 4:16 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		564,706	564,706	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001200	0.005500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		678	3,106	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		182	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		860	3,153	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		590,078	590,078	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,504,504	1,504,504	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001457	0.005343	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,192	8,039	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		3,052	11,192	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		26	110	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		117.38	101.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		15	82	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,761	8,344	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			14,244	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)			10,105	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 8/31/2020 4:16 pm	
		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)		337,834	337,834	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001200	0.005500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		405	1,858	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		182	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		587	1,905	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		354,658	354,658	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		965,483	965,483	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001655	0.005371	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,598	5,186	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,185	7,091	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		59	228	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		37.03	31.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		30	145	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,111	4,510	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)			9,276	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)			5,621	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 8/31/2020 4:16 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		310,587	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		10/30/2019	5,413	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,413	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		316,000	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		193,590	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		509,590	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00		
		15101	2.00		
8.00	Name of Contractor	CGS			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 8/31/2020 4:16 pm	
		RHC II	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		58,387	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		58,387	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		113,169	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		171,556	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00